FY2005 Annual Summary

Suicide Prevention Hotlines in Georgia

July 2004 – June 2005

NATIONAL SUICIDE PREVENTION LIFELINE™
1-800-273-TALK
www.suicidepreventionlifeline.org

HOPE
1.800.SUICIDE
784.2433

Behavioral Health Link

Crisis, Access & Care Management: A Service of Integrated Health Resources

BEHAVIORAL HEALTH LINK℠

Access and Care Management A Service of INTEGRATED HEALTH RESOURCES

October 21, 2005

75 Piedmont Ave., NE, Suite 910
Atlanta, Georgia 30303

Please find enclosed with this letter an Annual Summary of the Suicide Prevention Hotlines in Georgia. Behavioral Health Link is the statewide provider for the **National Suicide Prevention Lifeline (1-800-273-TALK)** and the **National Hopeline Network (1-800-SUICIDE)**. We hope that the enclosed information will give you a broad picture of the how our Crisis Call Center is working for your communities. We are answering calls in every county of Georgia, and we want you to feel confident in offering this service to consumers in your area as we partner together to prevent suicide.

Behavioral Health Link is a division of Integrated Health Resources, a Georgia-owned company that provides crisis, access and care management services to consumers with mental health and addictive diseases. Our licensed professional staff is available 24/7 to help alleviate emotional distress. They provide screening, triage and linkage for consumers with multiple levels of need, from those needing information or routine referral to those who are in psychiatric or emotional crisis.

The National Suicide Prevention Lifeline grant is one component of the National Suicide Prevention Initiative (NSPI), a multi-project effort to reduce suicide led by the Substance Abuse and Mental Health Services Administration's Center for Mental Health Services. The Mental Health Association of New York City was awarded a three-year SAMHSA grant to administer 1-800-273-TALK, with secondary support from the National Association of State Mental Health Program Directors (NASMHPD). This network of over 100 certified crisis call centers nationwide is available 24/7 to talk to persons in emotional distress or having thoughts of ending their lives.

We are taking this opportunity to invite you to the **Grand Opening** of our new Atlanta Crisis Call Center on November 30, 2005 at 2:00 pm to see our operation, to meet Dr. John Draper, the Executive Director of 1-800-273-TALK and to better understand how these services impact all of our Georgia communities. Beginning September 11, 2001, Dr. Draper's 1-800-LIFENET New York City Crisis Call Center became the primary vehicle for mobilizing the largest disaster mental health response ever undertaken in the United States. He has intimate experience with the critical role Crisis Call Centers fill for their communities during these times. Recent studies have demonstrated that Crisis Call Centers make a difference – suicidal persons really do call to seek help and lives are often saved as a result. (I have included two summaries of these recent studies in your packet with comments from CMHS Director Kathryn Power.)

During fiscal year 2005, Behavioral Health Link answered approximately 5500 calls throughout Georgia on 1-800-273-TALK and 1-800-SUICIDE. We have collated this data to reflect where these calls come from and who the callers actually are. We have also included data that tells us more about suicide in Georgia. Who among us is most at risk? Where are they? And we must ask ourselves, how do we reach out to these neighbors, friends and family members? While Georgia has an overall rate slightly lower than the national average, several areas of our state have higher suicide rates and populations that are clearly not being reached. The enclosed packet includes suicide rates in your area for the following groups: African Americans, Caucasians, Hispanics, males, females, seniors and teens.

Our hope is that by providing this information for all of our Georgia communities and this opportunity to get to know Behavioral Health Link and Dr. John Draper we can create a better network to meet these needs and address these problems.

Feel free to share this information in your communities. We have included information from the 1-800-273-TALK program that can be used for marketing purposes and we would be glad to provide further information or materials if you're interested (wallet cards, magnets, etc.). In addition, we feel that the data that is specific to your communities is important to share with providers and planners. If you cannot attend our Grand Opening, but would like to discuss this information in more detail, please do not hesitate to contact me at dwcbhl@ihrcorp.com or 1-800-273-TALK. Thank you, and I hope to see you on November 30.

Sincerely,

David Covington, NCC, LPC, MBA
Chief Operating Officer

Call Center Accreditation

Health Call Center URAC Accreditation

Integrated Health Resources, d/b/a Behavioral Health Link, has been accredited through URAC since 2000. IHR maintained a Utilization Management module up until fall 2004, as the company has historically performed significant managed care activities. As the company began growing its crisis and access management services, the decision was made to obtain a credential specific to the call center functions. IHR first obtained the Health Call Center credential in 2002 and this accreditation currently extends through 2007.

What is URAC?

What Joint Commission and CARF are for the accreditation of behavioral healthcare service delivery, URAC and NCQA are for the accreditation of behavioral healthcare support services. URAC's broad-based membership include all constituencies affected by healthcare – employers, consumers, regulators, health care providers and the workers' compensation and managed care industries.

URAC's Accreditation Programs

Case Management	Claims Processing	Consumer Education & Support	Core Accreditation
Credentials Verification Organization	Disease Management	Health Call Center	Health Network
Health Plan	Health Provider Credentialing	Health Utilization Management	Health Web Site
HIPAA Privacy	HIPAA Security	Independent Review	Workers' Compensation Utilization Management

What does the URAC Health Call Center accreditation mean?

The accreditation process takes place over the course of a three month period with three major stages: 1) desktop review, 2) on-site review and 3) committee review. URAC surveyors are full-time in their roles and do not work for other behavioral healthcare agencies. Integrated Health Resources, d/b/a Behavioral Health Link, has a URAC core accreditation plus the Health Call Center module. The requirements of this credential guide many of the policies and procedures utilized by the IHR crisis and access call center.

For example, the following Behavioral Health Link practices are founded on URAC guidelines:

- ***Licensed clinicians*** – 24/7 answer by an LCSW, LPC or RN as clinical triage must be performed by a credentialed professional
- ***Medical Director Supervision*** – Clinical oversight by actively practicing physician as this is required for the ongoing evaluation and revision of clinical decision support tools
- ***Outstanding Call Coverage*** – Phone statistics (blockage, abandonment and average speed of answer) continuously reviewed as a live person must answer within industry standards

Crisis Certification

American Association of Suicidology Certification

Integrated Health Resources, d/b/a Behavioral Health Link, has been certified as a Crisis Call Center through the American Association of Suicidology since 2002. IHR pursued inclusion in the National Hopeline Network in response to a series of teen suicides in the coastal area of Georgia in 2001. Over 100 certified crisis call centers across the country answer the 1-800-SUICIDE hotline, which was originated with a SAMHSA grant to the Kristen Brooks Hopeline. The American Association of Suicidology received a portion of the funding of this grant to certify crisis call centers for the network, and AAS has become the gold standard.

What is AAS?

Founded in 1968 by Edwin S. Shneidman, Ph.D., considered by many the father of Suicidology, AAS promotes research, public awareness programs, and training for professionals and volunteers. In addition, AAS serves as a national clearinghouse for information on suicide and sponsors an annual conference on suicide prevention that includes collaboration among certified call centers. AAS has also published an official journal, Suicide and Life-Threatening Behavior, for three decades.

Area I	Administration/Organizational Structure	Area IV	Services in Life-threatening Crises
		Area V	Ethical Standards And Practice
Area II	Training Program	Area VI	Community Integration
Area III	General Service Delivery System	Area VII	Program Evaluation

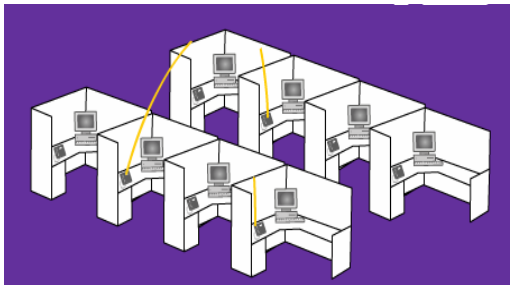
What does the AAS Crisis Center certification mean?

The AAS Certification Standards are designed to assist agencies evaluate their crisis programs by measuring them against minimum standards of service. The standards defined in the AAS Certification Standards Manual are based on the values of the American Association of Suicidology and require that an agency demonstrates it acts within certain core philosophies. These include:

- ***Active Intervention*** – Care Managers make every attempt to engage a caller who is a danger to themselves or others to voluntarily seek treatment. However, when this cannot be attained, IHR staff does everything possible to save a life, e.g., trace calls and dispatch emergency personnel.
- ***Follow-up of High Risk Callers*** – Care Managers follow-up on emergent and urgent cases to ensure the person received the face-to-face assessment agreed to over the phone.
- ***Third Party Callers*** – When friends, family or co-workers call about someone they feel may be suicidal, our Care Managers contact the individual directly.

Advanced Telephony

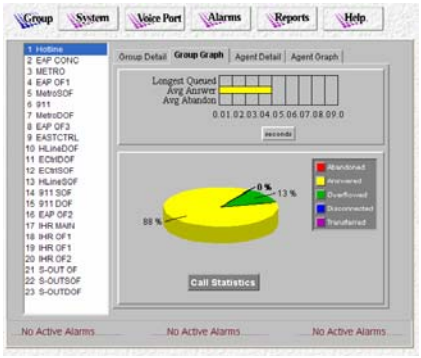
Nortel Norstar
Integrated Communications System (ICS)



Integrated Health Resources, d/b/a Behavioral Health Link, has been utilizing the Nortel Norstar Integrated Communications System (ICS) since 2002. With 35 incoming telephone lines and a scalable design, IHR can expand and evolve as business needs require. The Norstar ICS supports up to a maximum of 64 phone sets. IHR is currently receiving over 100,000 incoming psychiatric crisis/access calls annually, but the Norstar ICS can easily support five to ten times that volume.

The compact ICS has one of the highest reliability rates in the industry as measured by a meantime between failure rate over 100 years. An easy to use LCD window on the phone set cues the Care Manager on the origination of a call (including caller ID). The system also permits supervisory support and silent phone monitoring for quality control.

Cintech Cinphony II
Automated Call Distribution (ACD)



IHR utilizes an Automated Call Distribution system that routes incoming calls into call groups according to pre-determined protocols and tracks call data for reporting purposes. This system permits IHR to integrate the assets of call centers in Atlanta and Augusta to achieve maximum capacity and coverage. If all clinicians are busy with other callers, the ACD system overflows calls to supervisory staff.

What is Advanced Telephony?

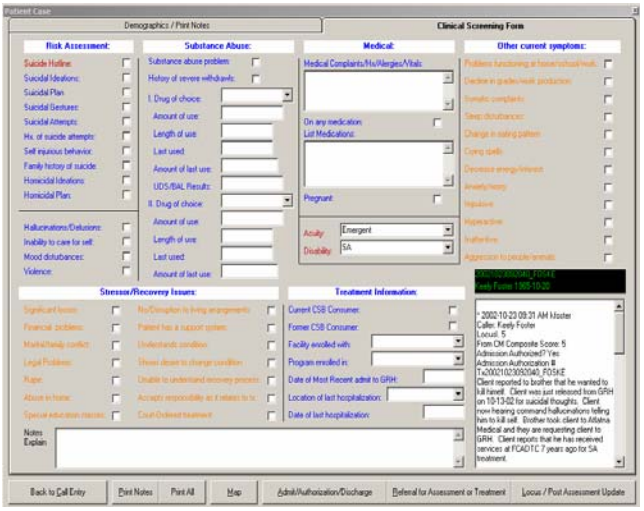
The power of the Norstar ICS and Cinphony ACD systems partnered together gives IHR a robust platform to deliver the highest quality call center services, highlighted by the following:

- ***Highest Answer Rates*** – Average abandonment rate of less than 1% during 2005 (meaning that over 99% of callers who hold a minimum of 30 seconds actually talk with a live clinician)
- ***Productivity Measurement*** – Appropriate coverage and cost containment is accomplished by requiring clinician Care Managers to answer calls according to productivity standards.

Data Management

Caller/Consumer Information Database

Integrated Health Resources, d/b/a Behavioral Health Link, developed a proprietary database for crisis and access management information in 2002. The IHR Caller/Consumer Information Database (CCID) was built in Visual Basic upon a Microsoft SQL platform. Whereas Microsoft Access limits the user to 64,000 records, Microsoft SQL supports millions of records. IHR maintains a database of all caller interactions dating back to 2002 and continuously makes appropriate revisions based on contract needs.



Consumer Driven Technology

Clinician Care Managers who answer the phones in the IHR crisis and access Health Call Centers enter data into the CCID in real-time as they facilitate phone calls. This results in the highest level of productivity and ensures that caller/consumer information is always at the fingertips of whoever answers the phone, whether in IHR's Atlanta or Augusta Crisis/Access Call Center. In addition to benefits to the caller, this database encourages reporting of clinical and demographic profiles and service deficits that inform policy and systems development.

IHR Caller/Consumer Information Database

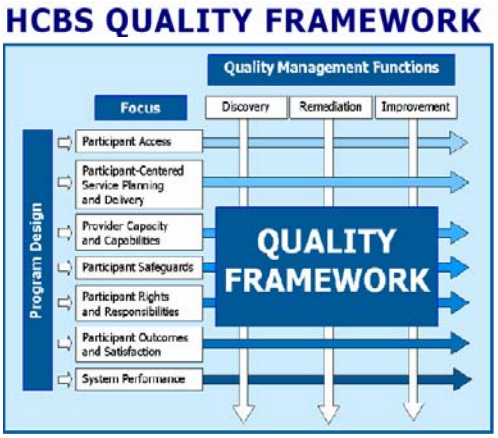
Demographics	Clinical		Provider Linkage
Home Address	Presenting Problem	Risk Assessment	Current Treatment
Age/Sex/Race	Substance Abuse History	Stressors/Recovery Issues	Provider Linkage
Eligibility Determination	Co-morbid Medical	Acuity Determination	LOCUS Determination

Collaborative Partnerships

Advisory Stakeholder Council

Integrated Health Resources, d/b/a Behavioral Health Link, has facilitated a Quality Improvement Advisory Council for key stakeholders since 2002. Community Councils meet every other month in Atlanta and Augusta to provide input to the services delivered by the IHR Crisis/Access Call Centers. The founding members are key representatives from the following:

- Georgia Department of Human Resources
- Regional state hospital (GRH/Atlanta)
- Local Community Mental Health Center (Fulton County)
- Largest local psychiatric emergency room (Grady Hospital)



Consumer and Family Input

The Community Councils have expanded over time to include private psychiatric hospitals, behavioral healthcare providers, law enforcement and other agencies dedicated to issues such as aging. IHR has recently begun incorporating input from consumers, family members and advocates.

The HCBS Quality Framework

IHR utilizes the framework developed by CMS (Centers for Medicare and Medicaid Services) for improving quality within Home and Community-Based Services. This approach emphasizes outcomes and satisfaction for the caller/consumer.

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Diversity & Georgia-Based

Georgia Crisis/Access Call Centers

Integrated Health Resources, d/b/a Behavioral Health Link, has maintained a corporate office in Augusta since 1995. IHR operates Crisis/Access Call Centers in Atlanta and Augusta and is intimately knowledgeable of resources in all five MHDDAD regions. Georgia callers talk with professionals who live in Georgia.




Strength in Diversity

Nearly 50% of the population in Fulton and Clayton counties is African American, and Georgia's African American composition is well above the national average (29% versus 12%). This racial group comprises nearly two-thirds of callers to IHR's local crisis/access lines and one-third of callers for the national suicide hotlines. The IHR team is representative of this strength (see table below).

IHR is also committed to developing increased Spanish-language capacity and has recently added a Hispanic crisis counselor.

IHR Team African American Composition

40% of Executive Team	50% of Supervisory Team	65% of Crisis/Access Call Center Team

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Integrated Health Resources

Integrated Health Resources operates three major books of business: Behavioral Health Link, CONCERN: Employee Assistance Programs and IHR Consulting. With corporate headquarters in Augusta and a Health Call Center hub in Atlanta, IHR offers 24/7 crisis and access support through licensed professionals.

IHR's Spectrum of Services

IHR Consulting	Behavioral Health Link			CONCERN: EAP
Consulting	**Crisis**	**Access & Linkage**	**Care Management**	**EAP Services**
Planning Mgmt Support	Telephone Crisis Triage	Service Entry & Linkage	Gatekeeping/ Single Portal	Client Service/ Mgmt Support
Grant Application Preparation	Suicide Hotline Intervention	Brokerage/ Advocacy	Hospital Liaisons	Customized Training
Project Management	Mobile Crisis Assessment	Community Education	Utilization Review	Critical Incident Stress Debriefing

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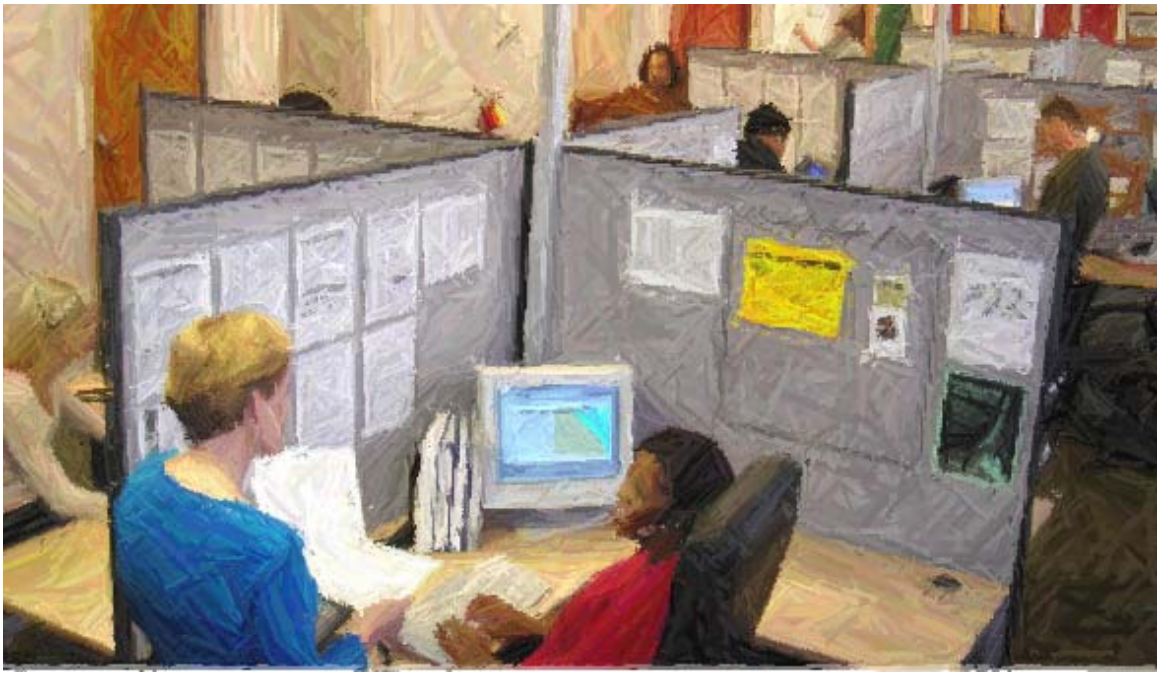
Suicide Prevention Hotlines



Executive Summary

July 2004 – June 2005

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FY 2005 Annual Summary
Behavioral Health Link

National Suicide Hotlines

Description of Service

Integrated Health Resources, d/b/a Behavioral Health Link, is a member of the two national networks that provide suicide hotline coverage in Georgia:

- 1-800-273-TALK (National Suicide Prevention Lifeline) funded by SAMHSA
- 1-800-SUICIDE (the Hopeline Network) funded by NMHA

IHR serves as the exclusive Crisis/Access Call Center for both networks in all 159 counties of Georgia.

Historical Setting

IHR pursued inclusion in the National Hopeline Network in response to a series of teen suicides in the coastal area of Georgia in 2001. At that time, IHR was providing "Single Point of Entry" services in Savannah, Atlanta and Augusta. IHR obtained certification through the American Association of Suicidology (required for membership in the national network) and began providing primary coverage in area codes 912 and 404 in 2002.

Fiscal Year 2005

In July 2004, the other agency in Georgia providing this service discontinued their affiliation with the network citing budgetary constraints. Since that time, IHR has been providing coverage for the entire state of Georgia. In Fiscal Year 2005, the IHR Crisis/Access Call Centers received 5,556 incoming calls on 1-800-SUICIDE and 1-800-273-TALK.

MHA of NYC & 1-800-273-TALK

On January 1, 2005, SAMHSA and MHA of NYC launched a new national suicide line, 1-800-273-TALK. The National Suicide Prevention Lifeline (NSPL) grant is one component of the National Suicide Prevention Initiative, a multiproject effort led by SAMHSA's Center for Mental Health Services.

The NSPL grant is administered through the Mental Health Association of New York City. Beginning September 11, 2001, Dr. John Draper's 1-800-LIFENET crisis call center became the primary vehicle for mobilizing the largest disaster mental health response ever undertaken in the United States. As the Director of

1-800-273-TALK, Dr. Draper has extensive experience in suicide prevention and crisis center management.

MHA of NYC has provided a packet of marketing materials on their website that is available for download. This information is included in Section I of this notebook.

Typical Caller Profile

Section II of this document contains a demographic analysis of the new cases fully triaged by the IHR Crisis/Access Call Center for the two national suicide hotlines during FY2005.

More females used the suicide hotline service than males (61% versus 39%) and Caucasians were the predominant racial category (65%).

Acuity levels were evenly distributed with 30% triaged as emergent, 24% as urgent and 30% as routine. Mental health problems were by far the primary disability (87%) but there were some few with primary addictions (5%) or co-occurring disorders (8%).

The vast majority of callers were between the ages of 18 and 65 (85%). 53% of callers were determined to be "self-pay," with a significant number possessing benefits, e.g., Private Insurance (34%), Medicaid (8%). No callers of Limited English Proficiency reached IHR through the suicide hotlines.

Market Penetration

The overall market penetration of the national suicide hotlines in Georgia is 7.2 cases per 100,000 persons. African Americans and Caucasians are calling at similar rates (5.3 versus 4.4 per 100,000). Hispanics, teens and seniors are under-utilizing the service (1.3, 2.0 and 1.7 per 100,000, respectively). The rate of usage in large cities is extremely high versus other categories (19.3 per 100,000 persons).

Statewide Needs

Section III provides drill-down information on suicides by county in Georgia. Each graph highlights the five MHDDAD regions of the state and compares them with the Georgia and national averages. Fulton and Augusta (Serenity BHS area) are also included to benchmark against IHR's Single Point of Entry data.

While Georgia rates are below the national average overall, there are sub-segments that are not. For example, Caucasians in Georgia are more likely to end their lives by suicide than the national average. The rates for seniors are also very high compared to other states.

The tables at the conclusion of this section give more detailed information for MHDDAD regions and Community Service Board areas. For example, the suicide rate in Haralson County is nearly four times the state average. Region 4 (Southwest) was the highest in Georgia and above national averages in many categories.

Goals for Fiscal Year 2006

Participate in Kalafat/Gould Outcomes Study (Phase II)

Section IV includes synopses of two outcomes studies demonstrating the positive impact of Crisis Call Centers. Dr. Kathryn Power, SAMHSA Director, commented on these research results in March 2005 when they were presented to the 1-800-273-TALK Steering Committee. They were also highlighted at the American Association of Suicidology 2005 Annual Crisis Center Conference in Denver.

Target Key Underserved Populations

IHR has added a Hispanic staff to develop a Spanish language program with dedicated hours for the Crisis/Access Call Center. The Director of Community Affairs will also focus on teens and seniors in FY2006.

Obtain Three Year AAS Recertification

AAS will perform its recertification site visit of IHR in October 2005. IHR is also incrementally AAS-certifying individual staff members, beginning with its supervisory and management teams.

Disaster Response

After Hurricane Katrina displaced thousands of persons, IHR provided assistance with overflow coverage for New Orleans and Houston, as well as sending the Director of Clinical Services to Baton Rouge for a week. IHR is currently working with DHR on a FEMA temporary services grant to provide an outreach campaign to those evacuees residing in Georgia.

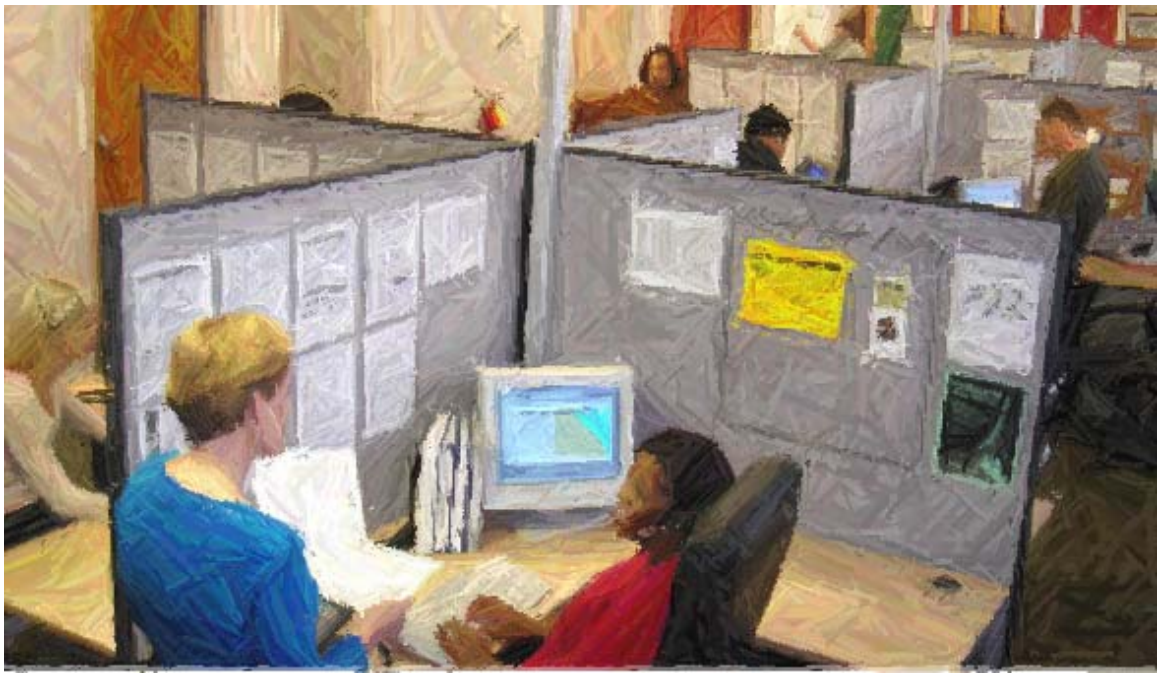
Maintain Quality Coverage with Increasing Call Volume

IHR received one-time funding from DHR in FY2005 to support suicide hotlines. Current levels of volume will severely tax IHR resources unless other revenue sources can be obtained in FY06.

Participate in 1-800-273-TALK Development

IHR Chief Operating Officer David Covington was named Vice-Chair of the 1-800-273-TALK Steering Committee in September 2005.

Suicide Prevention Hotlines



Section I

1-800-273-TALK

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www.suicidepreventionlifeline.org

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
www.samhsa.gov

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Background Information

On January 1, 2005, the U.S. Department of Health and Human Services' Substance Abuse and Mental Health Services Administration (SAMHSA) and Mental Health Association of New York City (MHA of NYC) launched the **National Suicide Prevention Lifeline, 1-800-273-TALK**.

The Lifeline is a network of more than 100 certified crisis centers nationwide. People who are in emotional distress or suicidal crisis can call at any time, from anywhere in the Nation, to talk with a trained worker who will listen to and assist callers in getting the help they need. Calls within the network are routed to an available crisis center closest to the caller, providing callers with immediate access to local resources, referrals, and expertise.

This national hotline network is part of the National Suicide Prevention Initiative (www.mentalhealth.samhsa.gov/cmhs/nspi/), a collaborative multiproject effort led by SAMHSA's Center for Mental Health Services. The Initiative incorporates the best practices and research findings in suicide prevention and intervention with the goal of reducing the incidence of suicide nationwide.

Suicide currently is the 11th leading cause of death among all age groups in the United States, accounting for more than 30,000 deaths annually. As the lead agency tasked with advancing the goals of the President's New Freedom Commission on Mental Health (www.mentalhealthcommission.gov/) and the National Strategy for Suicide Prevention (www.mentalhealth.samhsa.gov/suicideprevention/strategy.asp), SAMHSA is committed to working with State and local organizations—such as MHA of NYC, National Association of State Mental Health Program Directors, experts and researchers in suicidology, and community crisis centers—to expand the availability of suicide prevention and intervention services.

As part of the National Suicide Prevention Initiative, the Lifeline has created this media outreach toolkit that contains suicide warning signs wallet cards, magnets, posters, and print public service announcements. These materials should be customized by networked crisis centers; Federal, State, and county mental health agencies; and other stakeholder groups to promote and support suicide prevention, public education, and media outreach efforts in their communities. The materials are available for download on the Lifeline Web site: www.suicidepreventionlifeline.org. Limited quantities of the wallet cards and magnets also are available through the National Mental Health Information Center: 1-800-789-2647 or www.mentalhealth.samhsa.gov.

Guide for Marketing Activities

To supplement your media outreach activities, you can raise awareness of the **National Suicide Prevention Lifeline, 1-800-273-TALK**, further by disseminating the marketing materials in this section of the public education kit.

Placing Public Service Announcements

The Lifeline has produced two public service announcements (PSAs) for print publications—advertisements that publications will publish for free as a public service to the community if they have unsold advertising space and are inclined to publish the ad. These PSAs are aimed at two target audiences deemed to be at high risk for suicide:

- Males, ages 65 and older
- Males, ages 25 to 54.

Free advertising is a powerful way to get the message out that suicide is preventable and help is available.

Print Publications

You can get these PSAs published by researching the State, local, and regional print publications in your area, such as daily and weekly newspapers, magazines, journals, and newsletters. These may be aimed at the general public or specific audiences such as health care professionals, social services workers, educators, students, or business owners. Determine which publications would serve the target audience best for each of the three PSAs.

Create a publications list of names and contact information (e.g., phone and fax numbers and mailing and e-mail addresses) for each publication. You also may want to check with your local library or bookstore for information about media directories of daily and weekly newspapers, Internet news outlets, magazines, newsletters, and business trade publications in your community.

Some examples of media directories include Bacon's MediaSource (www.bacons.com) and the News Media Yellow Book (www.leadershipdirectories.com/nmyb.htm). Use your local phone book or the Internet to supplement your media list. You will need this information to send out the PSAs.

Create a cover letter to send with the PSAs. A sample letter that you can customize is included in this toolkit.

Billboards

A billboard is another vehicle for raising awareness of the Lifeline and your crisis center. Outdoor advertising companies often will run PSAs in the same way that print publications do—when they have unsold billboard space. Below is contact information for the Outdoor Advertising Association of America and two national companies.

Outdoor Advertising Association of America

www.oaaa.org

Clear Channel Communications

602-957-8116

www.clearchannel.com (Click on "Outdoor" then "Contact" for a listing of branch offices.)

Viacom

www.viacomoutdoor.com (Click on "Contact" for a listing of branch offices.)

A sample cover letter that you can customize is included in this toolkit.

Monitoring PSA Placement

The last critical step in disseminating the PSAs is to monitor the publications and billboard companies to which you have submitted the PSAs to determine whether they get published. When you submit a PSA to a print publication, ask the publication to send you a "tear sheet" (hardcopy of the ad as it appears in the publication) when they run the ad. Also, be sure to look through issues yourself, in case the publisher neglects to send you a copy. When you submit a PSA to a billboard company, ask for a "proof of performance" that includes the date the PSA was displayed and a photo of the billboard. To gauge the effectiveness of the PSAs, the Lifeline needs tangible evidence of their placement in local communities across the country. Please send notification of PSA placements (including copies of tear sheets and proofs of performance) to:

Lifeline Communications Team
c/o Social & Health Services, Ltd.
11420 Rockville Pike
Rockville, MD 20852
T: 1-800-790-2647
F: 301-468-6433
E: lifeline@samhsa.hhs.gov

Spreading the Word With Lifeline Wallet Cards, Magnets, Posters, and Flyers

The Lifeline wallet cards are a handy way for people to discreetly carry the warning signs of suicide and the toll-free number of the Lifeline. The magnets feature the Lifeline logo, which includes the toll-free number, **1-800-273-TALK**. You can help get these items into the hands of people who may be at risk for suicide and their loved ones by distributing them to doctors' offices, faith organizations, senior centers, community centers, and other gathering places in your area to inform people about the Lifeline network. The Lifeline posters and flyers also can be placed in these locations. These public education materials are available for download on the Lifeline Web site: www.suicidepreventionlifeline.org.

Wallet Cards

Suicide Warning Signs

Seek help as soon as possible by contacting a mental health professional or by calling the National Suicide Prevention Lifeline at 1-800-273-TALK if you or someone you know exhibits any of the following signs:

- Threatening to hurt or kill oneself or talking about wanting to hurt or kill oneself
- Looking for ways to kill oneself by seeking access to firearms, available pills, or other means
- Talking or writing about death, dying, or suicide when these actions are out of the ordinary for the person
- Feeling hopeless
- Feeling rage or uncontrolled anger or seeking revenge
- Acting reckless or engaging in risky activities—seemingly without thinking
- Feeling trapped—like there's no way out
- Increasing alcohol or drug use
- Withdrawing from friends, family, and society
- Feeling anxious, agitated, or unable to sleep or sleeping all the time
- Experiencing dramatic mood changes
- Seeing no reason for living or having no sense of purpose in life

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www.suicidepreventionlifeline.org

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
www.samhsa.gov

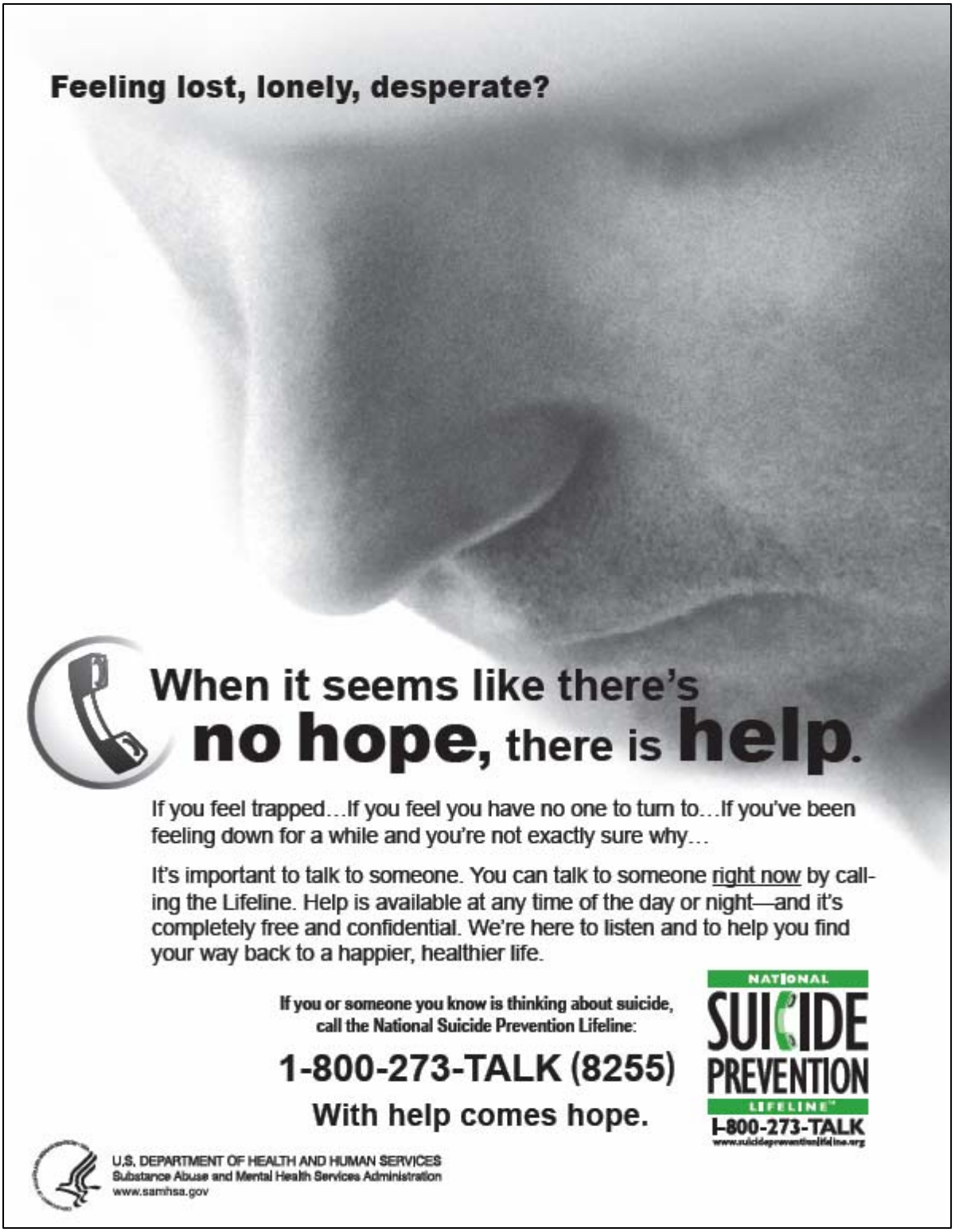
Are you or someone you love at risk of suicide?

NATIONAL SUICIDE PREVENTION LIFELINE™
1-800-273-TALK
www.suicidepreventionlifeline.org

Get the facts and take appropriate action.

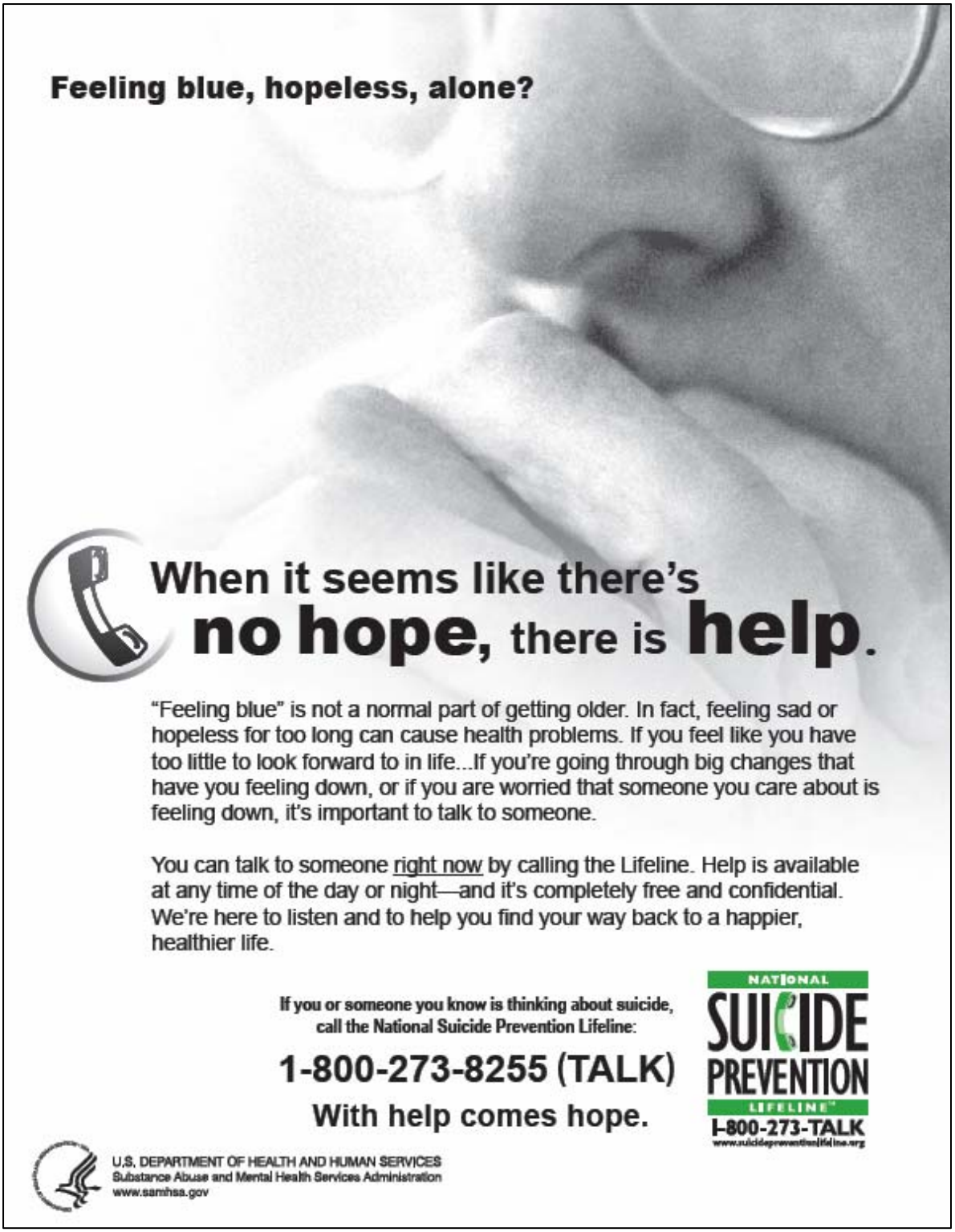
Print Public Service Announcement

(Target: Males, Age 25 to 54)



Print Public Service Announcement

(Target: Males, Age 65 and older)



Sample PSA Cover Letter

Dear **[name of media outlet public service director]**:

I am contacting you today to become a part of a national effort to reduce suicide. In collaboration with the U.S. Department of Health and Human Services (HHS) and the National Suicide Prevention Lifeline, the **[crisis center name]** has launched a public education campaign in **[community name]** to help people recognize the warning signs of suicide and to encourage them to call our toll-free crisis hotline, **[hotline number]**, or the **National Suicide Prevention Lifeline, 1-800-273-TALK (8255)**.

As part of this national effort, we hope that you will consider placing one or both of the attached public service announcements (PSAs) **[in your publication/on billboards in (State/community)]**. The PSAs, featured on the attached page and available electronically, are targeted at two different audiences that are at high risk for suicide:

- Males, ages 65 and older
- Males, ages 25 to 54.

These PSAs encourage your **[readers/viewers]** to call our 24-hour toll-free crisis hotline, **[hotline number]**, or the **National Suicide Prevention Lifeline, 1-800-273-TALK (8255)**, for help with a personal crisis or for more information about local mental health resources for themselves or someone they know.

[Crisis center name] is one of more than 100 certified crisis centers that participate in the Lifeline network (www.suicidepreventionlifeline.org). The National Suicide Prevention Lifeline is a federally funded national hotline network of local crisis centers administered by the Mental Health Association of New York City and supported by a grant from the Substance Abuse and Mental Health Services Administration's Center for Mental Health Services, an agency of HHS. Launched in January 2005, the Lifeline provides crisis counseling by trained helpers to anyone in need 24 hours a day, 7 days a week.

If you need more information about the PSAs, our center, or the Lifeline, please call me at the number below. **I will call you this week to follow up.** Thank you in advance for your support in helping us reach the hundreds of thousands of Americans who are at risk for suicide.

Sincerely,

Press Release Template

FOR IMMEDIATE RELEASE Media Contact: **[Insert contact name]**
[Insert date] [Insert telephone number & e-mail]

[Crisis Center Name] Launches Suicide Prevention Campaign

Campaign part of national effort launched by the
National Suicide Prevention Lifeline (1-800-273-TALK)

[Crisis center name] announced today that it is launching a public education campaign in **[community name]** as part of a national effort to reduce suicide. The campaign is designed to help people recognize the warning signs of suicide and to encourage people to call the **[crisis center name]**'s toll-free crisis hotline, [hotline number], or the **National Suicide Prevention Lifeline, 1-800-273-TALK (8255)**.

In **[name of State]**, more than **[latest statistic]** died by suicide in **[year]**. Across the country, someone dies by suicide every 17 minutes, accounting for more than 30,000 deaths annually. In the United States, more people die by suicide than by homicide. Worldwide, suicide accounts for nearly half of all violent deaths, nearly 1 million fatalities each year, according to the World Health Organization (WHO).

"As part of our local efforts to stop suicide, the **[crisis center name]** and our partners are sponsoring the **[name or type of event]**," said **[name]**, **[title]** of the **[crisis center name]**. "By working together locally and nationally with the National Suicide Prevention Lifeline, we are spreading the message that suicide is preventable and help is available for people in crisis."

[Insert brief paragraph (two sentences) to elaborate on your crisis center's efforts for National Suicide Prevention Week, National Depression Screening Day, National Mental Health Month, or other suicide prevention efforts.]

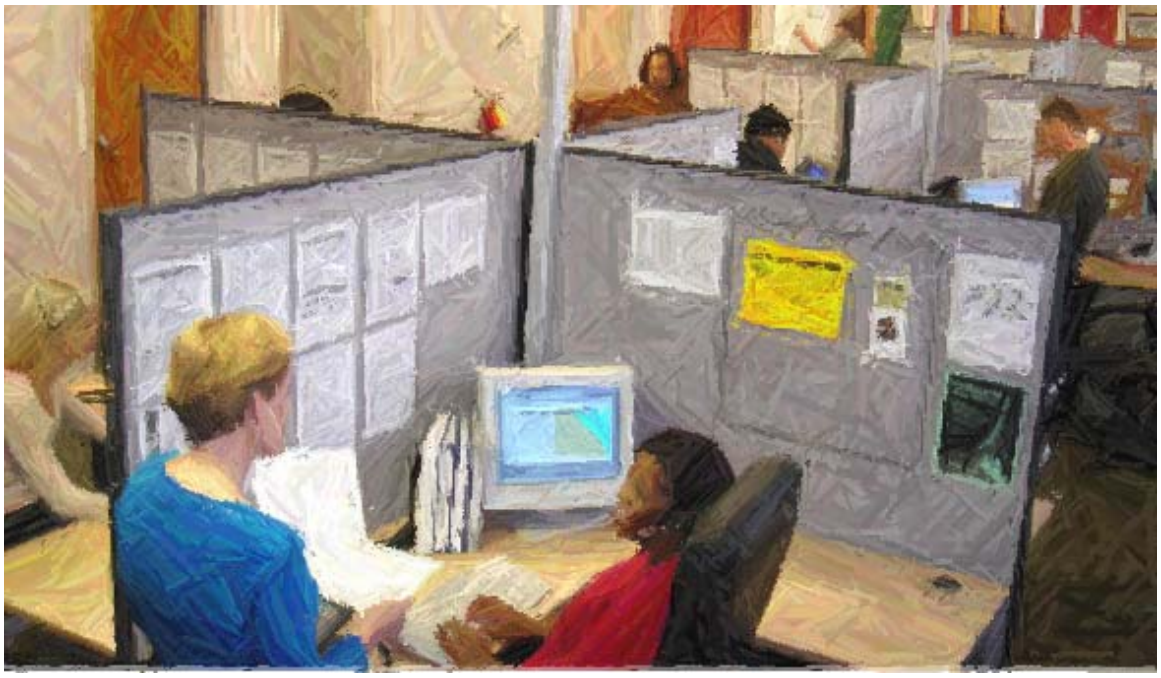
[Crisis center name] is one of more than 100 certified crisis centers that participate in the **Lifeline: 1-800-273-TALK** (www.suicidepreventionlifeline.org). The Lifeline is a federally funded national hotline network of local crisis centers administered by the Mental Health Association of New York City. Launched in January 2005, the Lifeline provides crisis counseling by trained helpers to anyone in need 24 hours a day, 7 days a week.

###

Message Points

- Suicide prevention is a national public health priority. Currently, suicide is the 11th leading cause of death among all age groups in the United States, accounting for more than 30,000 deaths annually. In **[insert your city, county, or service area name]**, more than **[insert number from your local statistics]** people die by suicide each year. That's why, in addition to providing suicide prevention services locally through our hotline, **[insert your crisis center's phone number]**, **[insert your crisis center's name]** has joined the **National Suicide Prevention Lifeline, 1-800-273-TALK**.
- **[Insert your crisis center's name]** is one of more than 100 certified crisis centers that participate in the National Suicide Prevention Lifeline network. What that means for us locally is that we are able to draw from a national pool of suicide prevention research and practices to help reduce suicide in **[insert your city, county, or service area name]**.
- As part of a national effort to reduce suicide, the U.S. Department of Health and Human Services' Substance Abuse and Mental Health Services Administration is supporting a public education campaign. For this campaign, the **National Suicide Prevention Lifeline, 1-800-273-TALK**, has created public education kits. **[insert your crisis center's name]** will use these materials—wallet cards, magnets, posters, and print public service announcements—to raise awareness of the **Lifeline, 1-800-273-TALK**, and our hotline, **[insert your hotline number]**, as confidential resources for people in crisis in our community.
- By working locally through **[insert your crisis center name and hotline number]** and nationally with the National Suicide Prevention Lifeline's public education materials, we hope to reduce the stigma, fear, and shame that may prevent people from reaching out for help during times of emotional distress or suicidal crisis.
- Our message **[for National Suicide Prevention Week/National Depression Screening Day/National Mental Health Month and beyond]** is that suicide can be prevented. This week, we are focusing on **[insert your local activities/events]**. Over the next few months, **[insert your crisis center's name]** will be printing and distributing the National Suicide Prevention Lifeline (Lifeline) public education materials to the community and working with our Lifeline colleagues to reduce the impact and incidence of suicide in **[insert your city, county, or service area name]**.

Suicide Prevention Hotlines



Section II

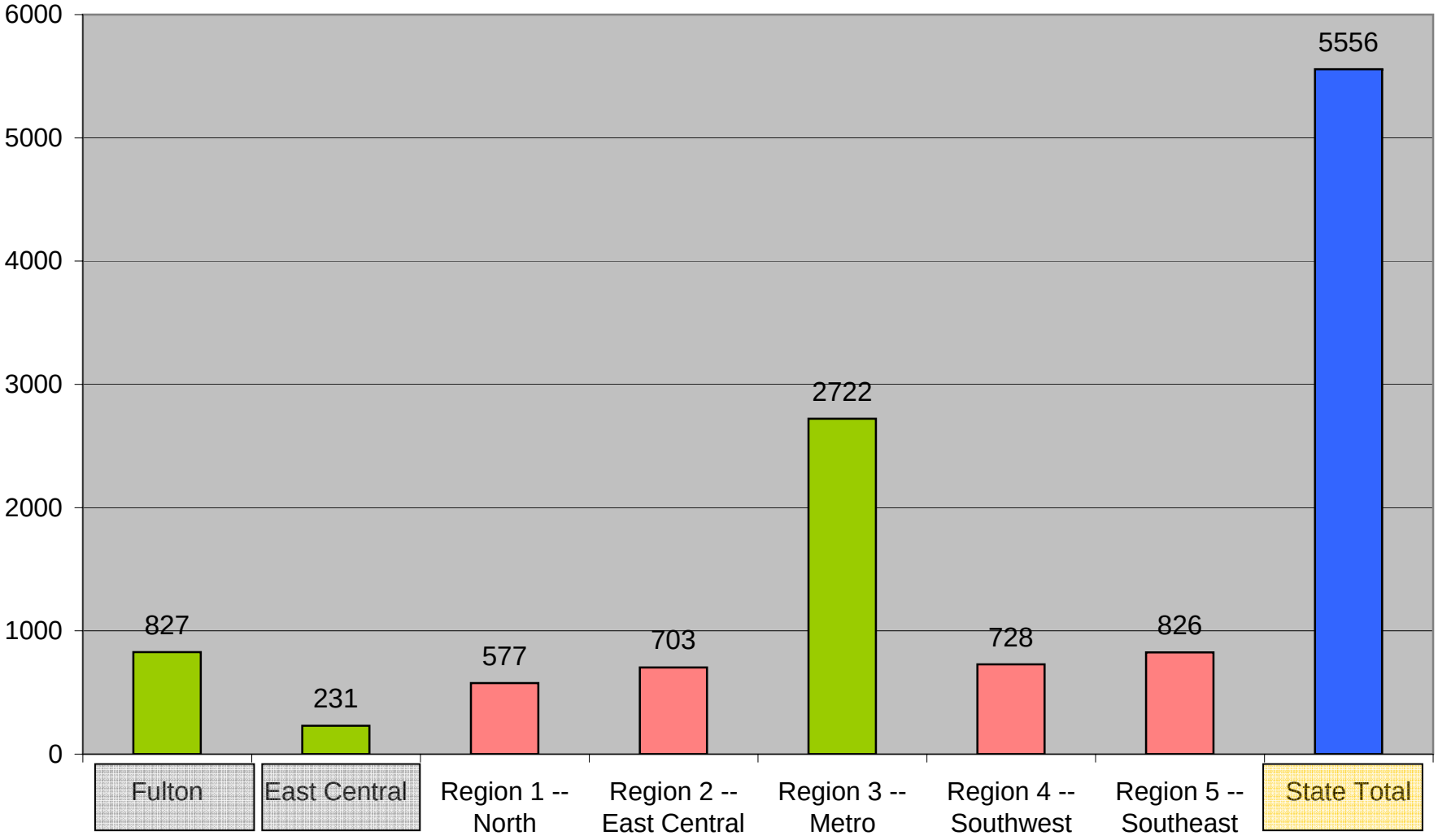
Georgia Caller Data

NATIONAL SUICIDE PREVENTION LIFELINE™
1-800-273-TALK
www.suicidepreventionlifeline.org

HOPE
1.800.SUICIDE
784.2433

National Suicide Lines FY2005 -- Incoming Calls

Behavioral Health Link Crisis & Access Health Call Center

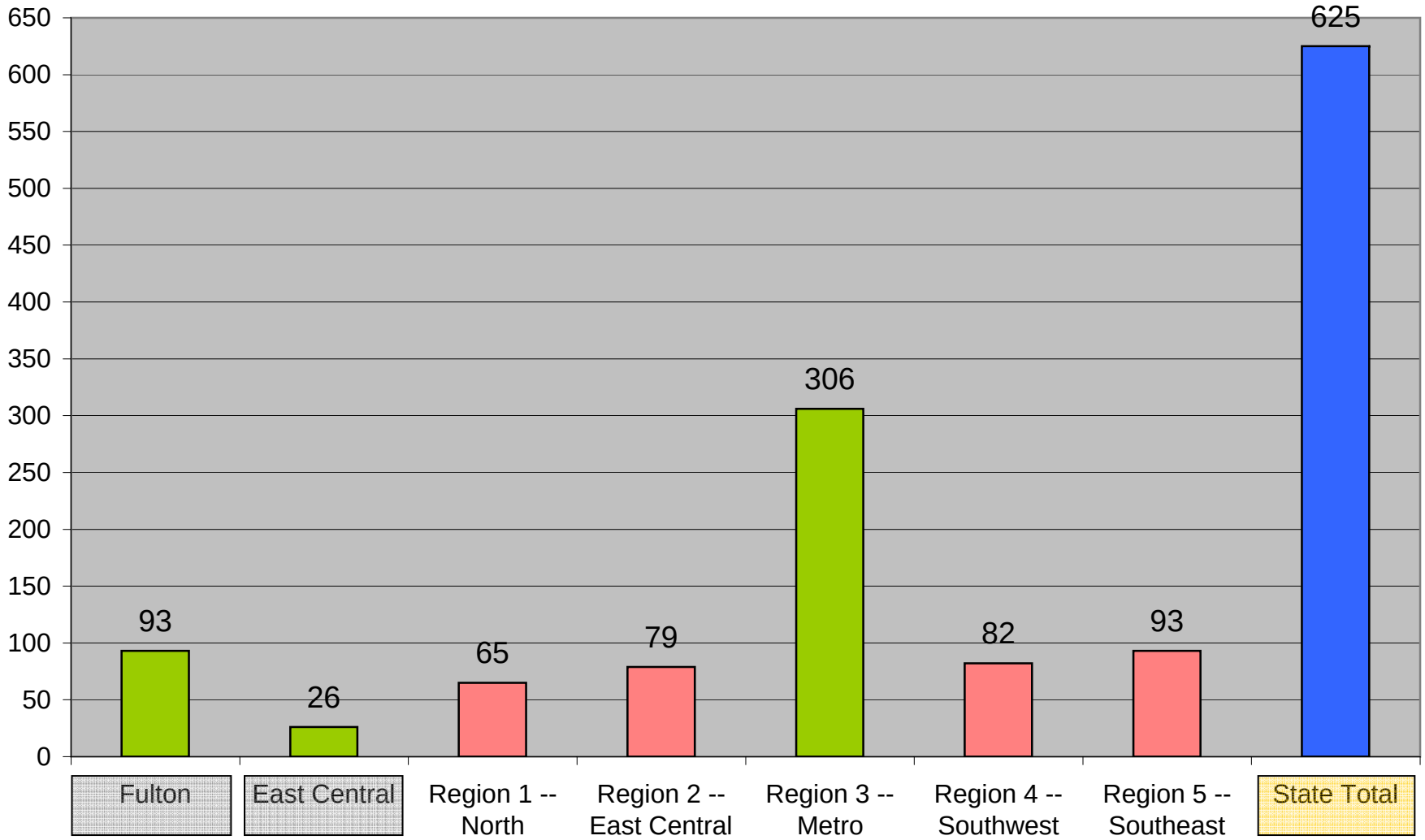


Behavioral Health Link℠

Crisis, Access & Care Management: A Service of Integrated Health Resources

National Suicide Lines FY2005 -- New Triaged Cases

Behavioral Health Link Crisis & Access Health Call Center

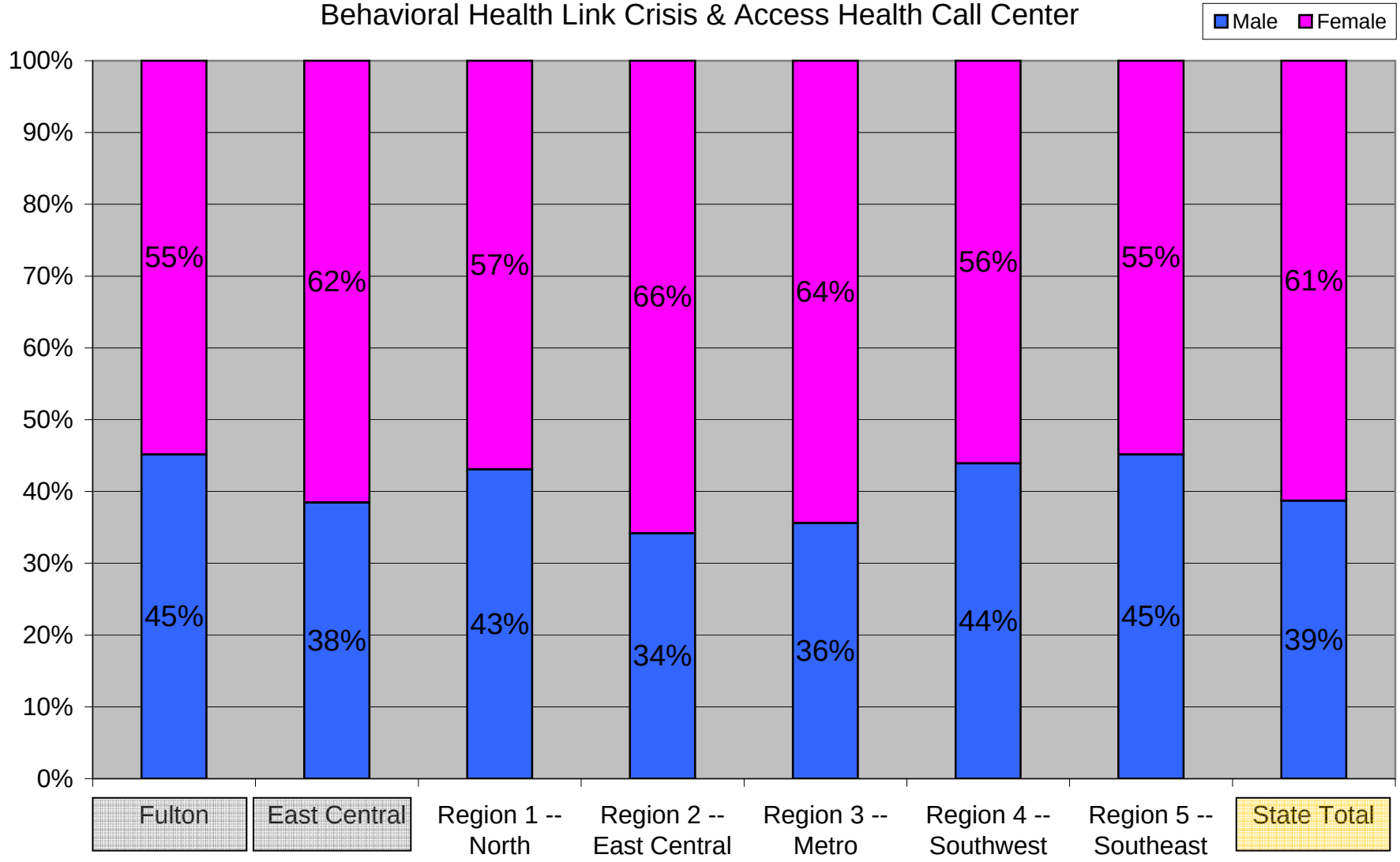


Behavioral Health Link℠

Crisis, Access & Care Management: A Service of Integrated Health Resources

National Suicide Lines FY2005 -- Gender

Behavioral Health Link Crisis & Access Health Call Center

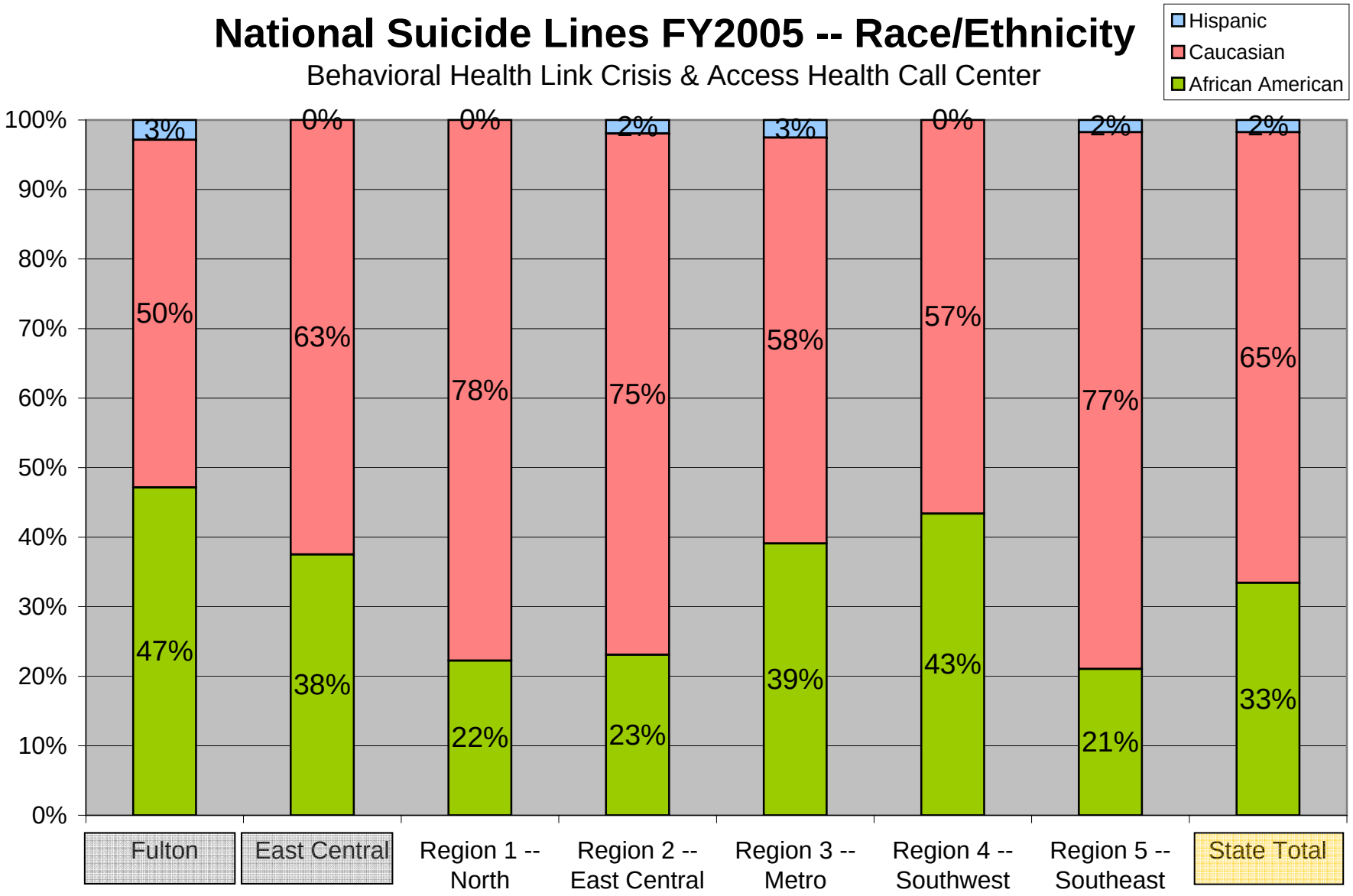


Behavioral Health Link℠

Crisis, Access & Care Management: A Service of Integrated Health Resources

National Suicide Lines FY2005 -- Race/Ethnicity

Behavioral Health Link Crisis & Access Health Call Center

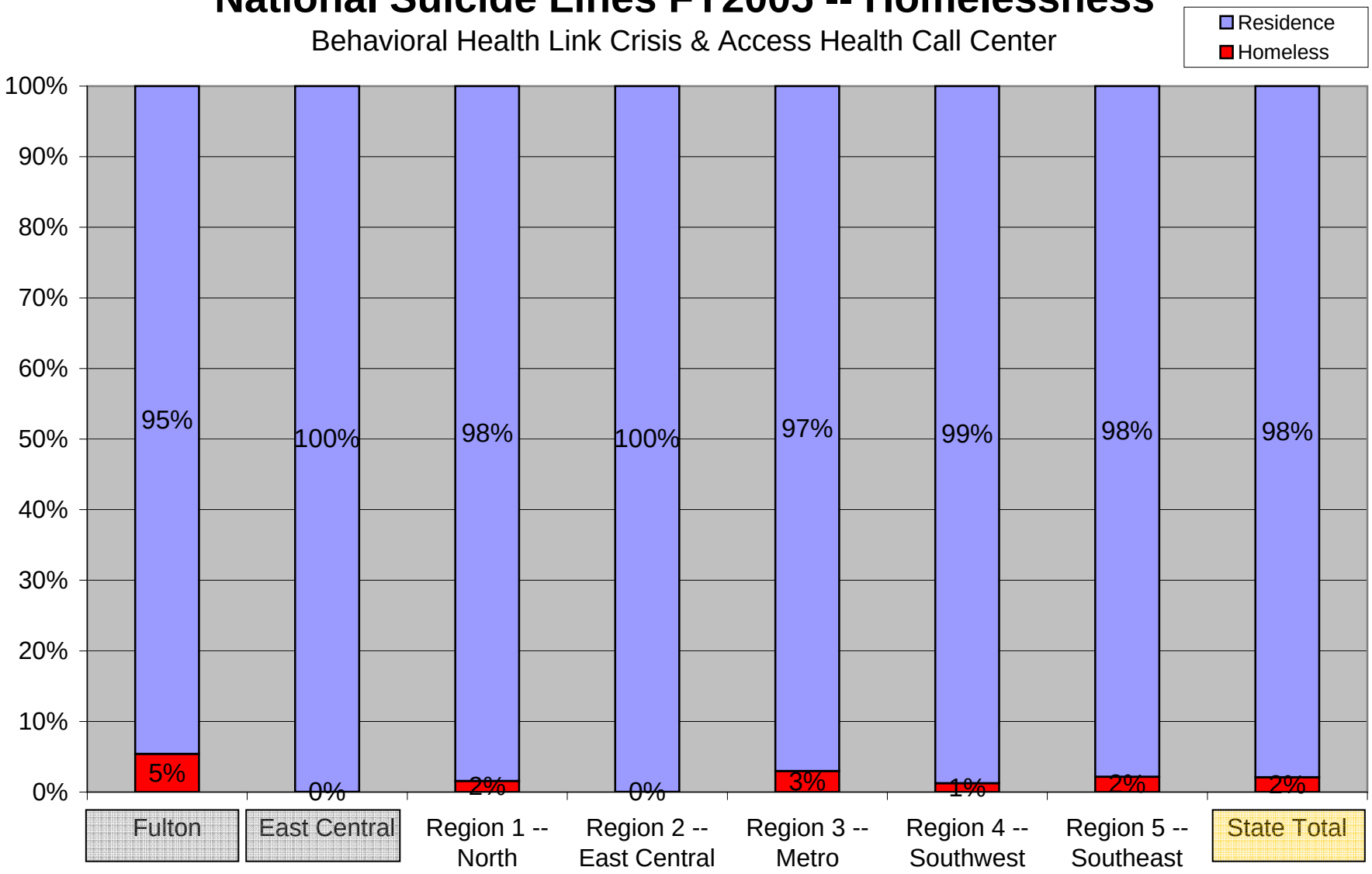


Behavioral Health Link℠

Crisis, Access & Care Management: A Service of Integrated Health Resources

National Suicide Lines FY2005 -- Homelessness

Behavioral Health Link Crisis & Access Health Call Center

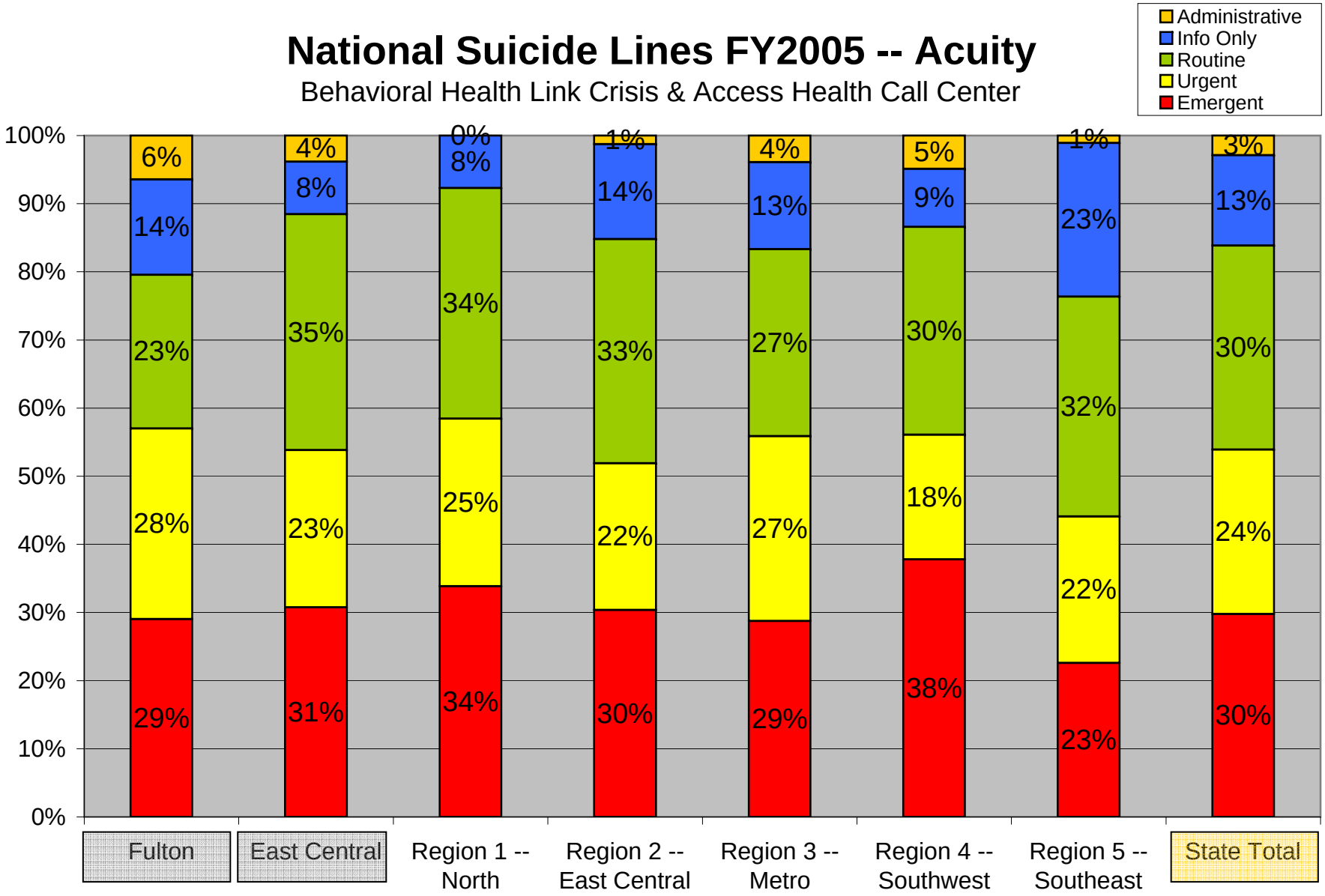


Behavioral Health Link℠

Crisis, Access & Care Management: A Service of Integrated Health Resources

National Suicide Lines FY2005 -- Acuity

Behavioral Health Link Crisis & Access Health Call Center

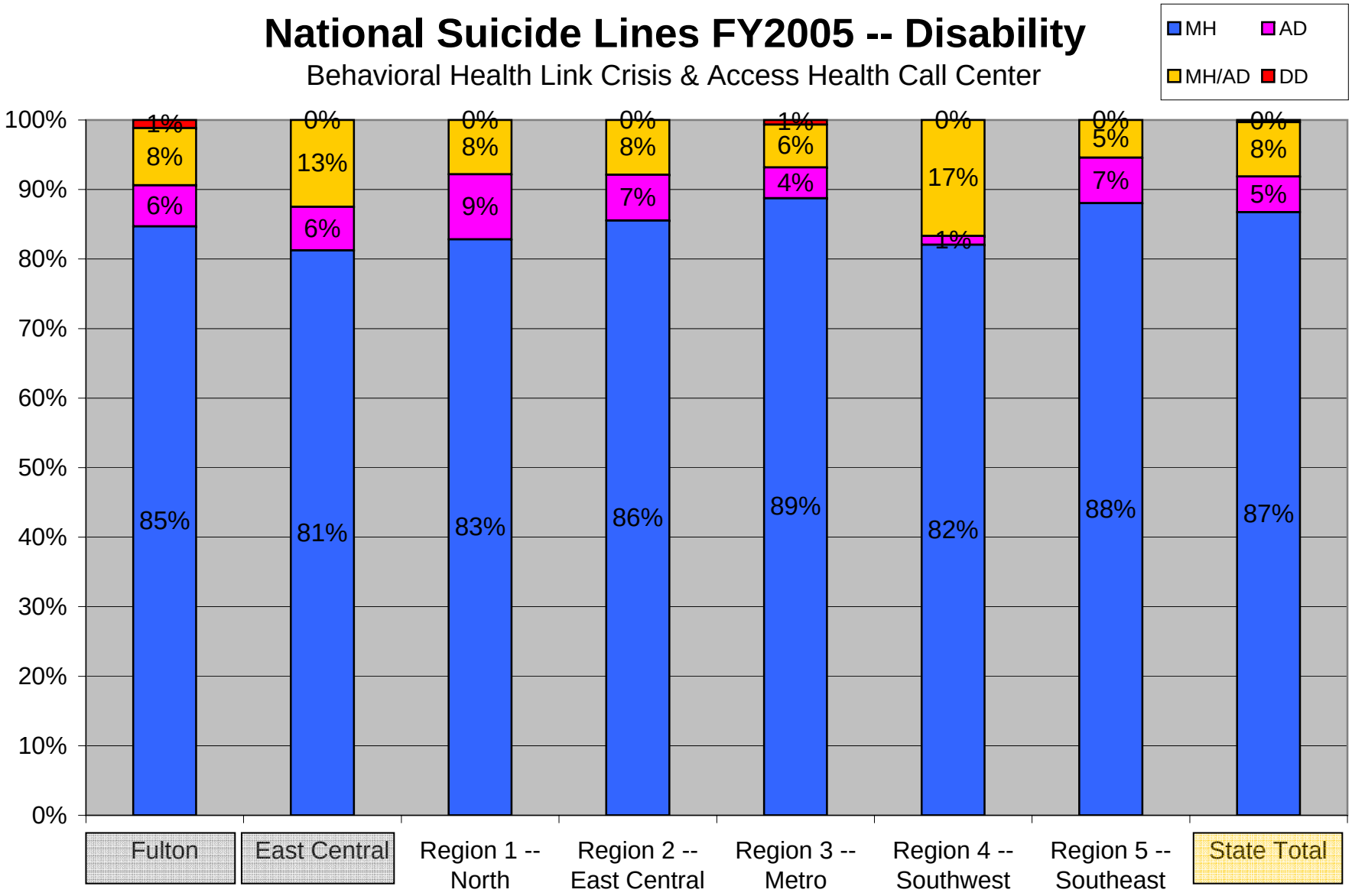


Behavioral Health Link℠

Crisis, Access & Care Management: A Service of Integrated Health Resources

National Suicide Lines FY2005 -- Disability

Behavioral Health Link Crisis & Access Health Call Center

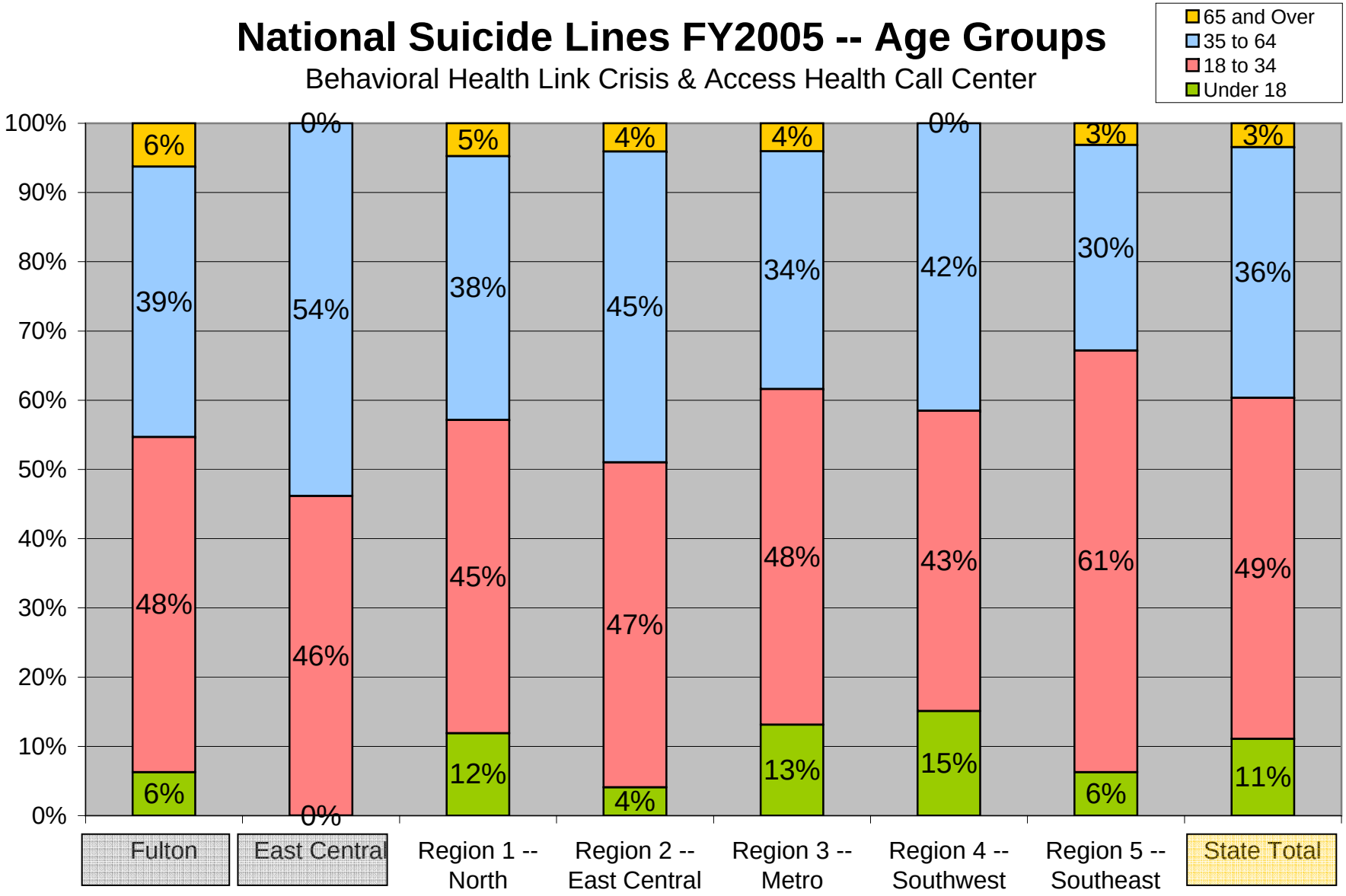


Behavioral Health Link℠

Crisis, Access & Care Management: A Service of Integrated Health Resources

National Suicide Lines FY2005 -- Age Groups

Behavioral Health Link Crisis & Access Health Call Center

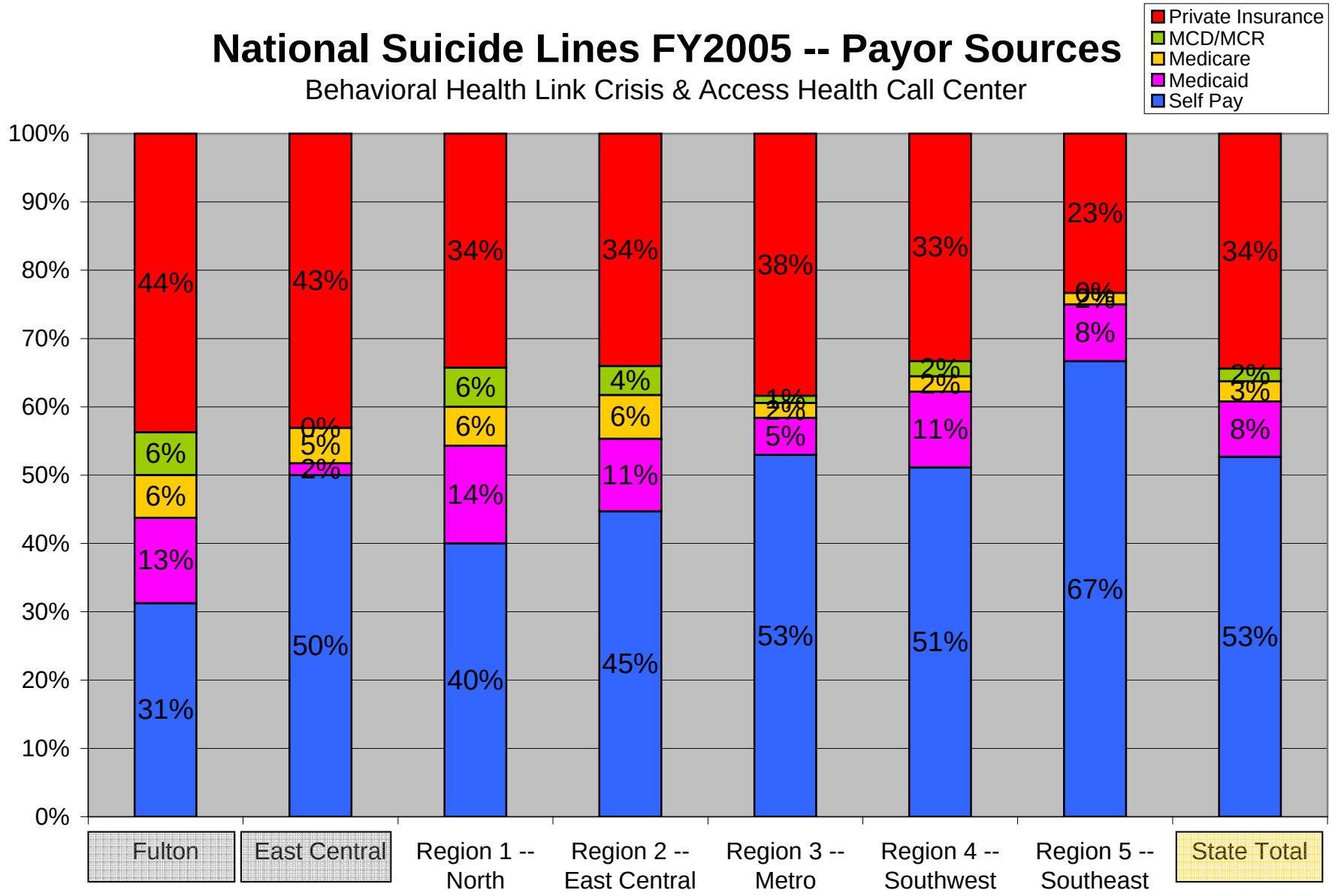


Behavioral Health Link℠

Crisis, Access & Care Management: A Service of Integrated Health Resources

National Suicide Lines FY2005 -- Payor Sources

Behavioral Health Link Crisis & Access Health Call Center

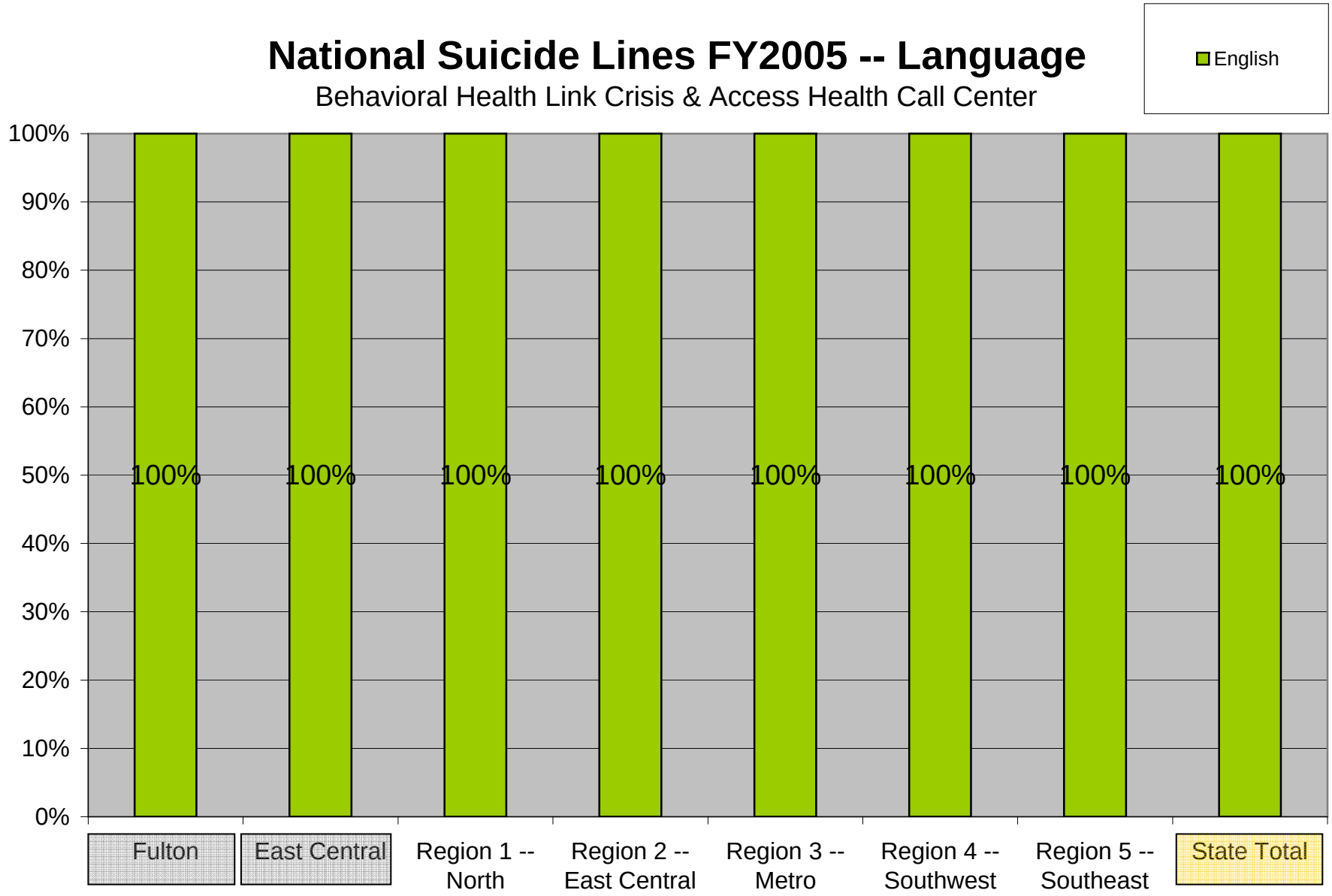


Behavioral Health Link℠

Crisis, Access & Care Management: A Service of Integrated Health Resources

National Suicide Lines FY2005 -- Language

Behavioral Health Link Crisis & Access Health Call Center

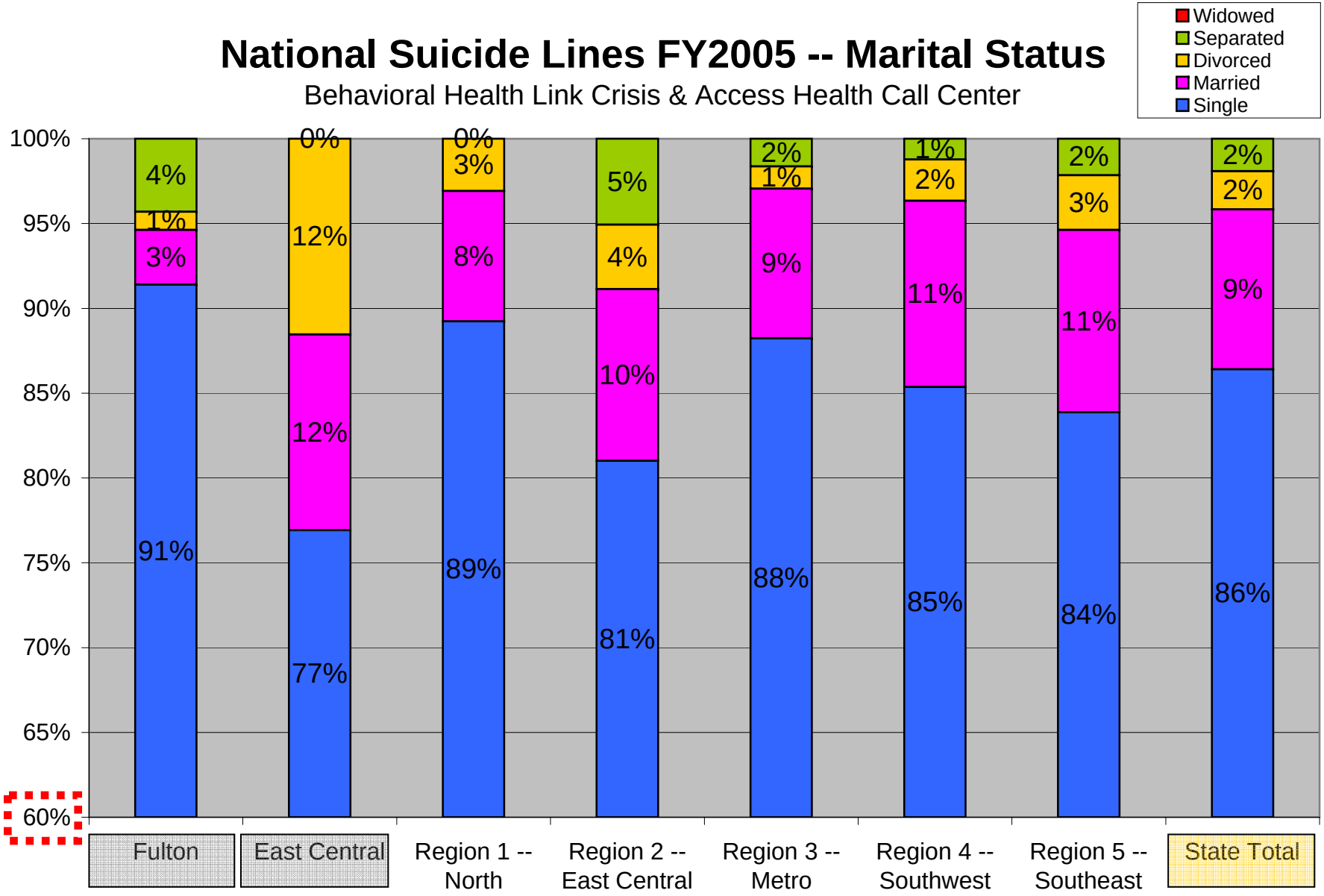


Behavioral Health Link℠

Crisis, Access & Care Management: A Service of Integrated Health Resources

National Suicide Lines FY2005 -- Marital Status

Behavioral Health Link Crisis & Access Health Call Center

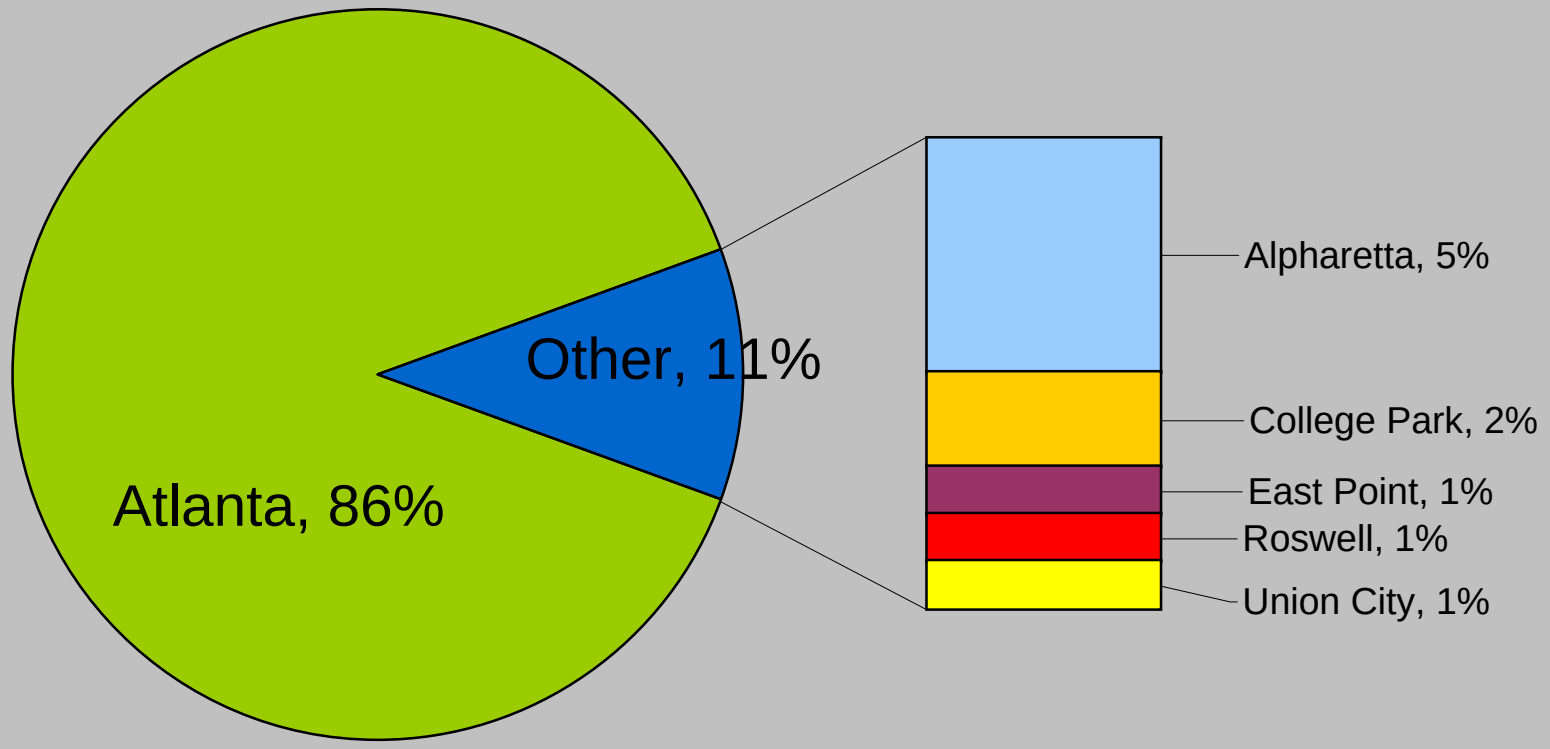


Behavioral Health Link℠

Crisis, Access & Care Management: A Service of Integrated Health Resources

National Suicide Lines FY2005 -- Fulton Cities

Behavioral Health Link Crisis & Access Health Call Center

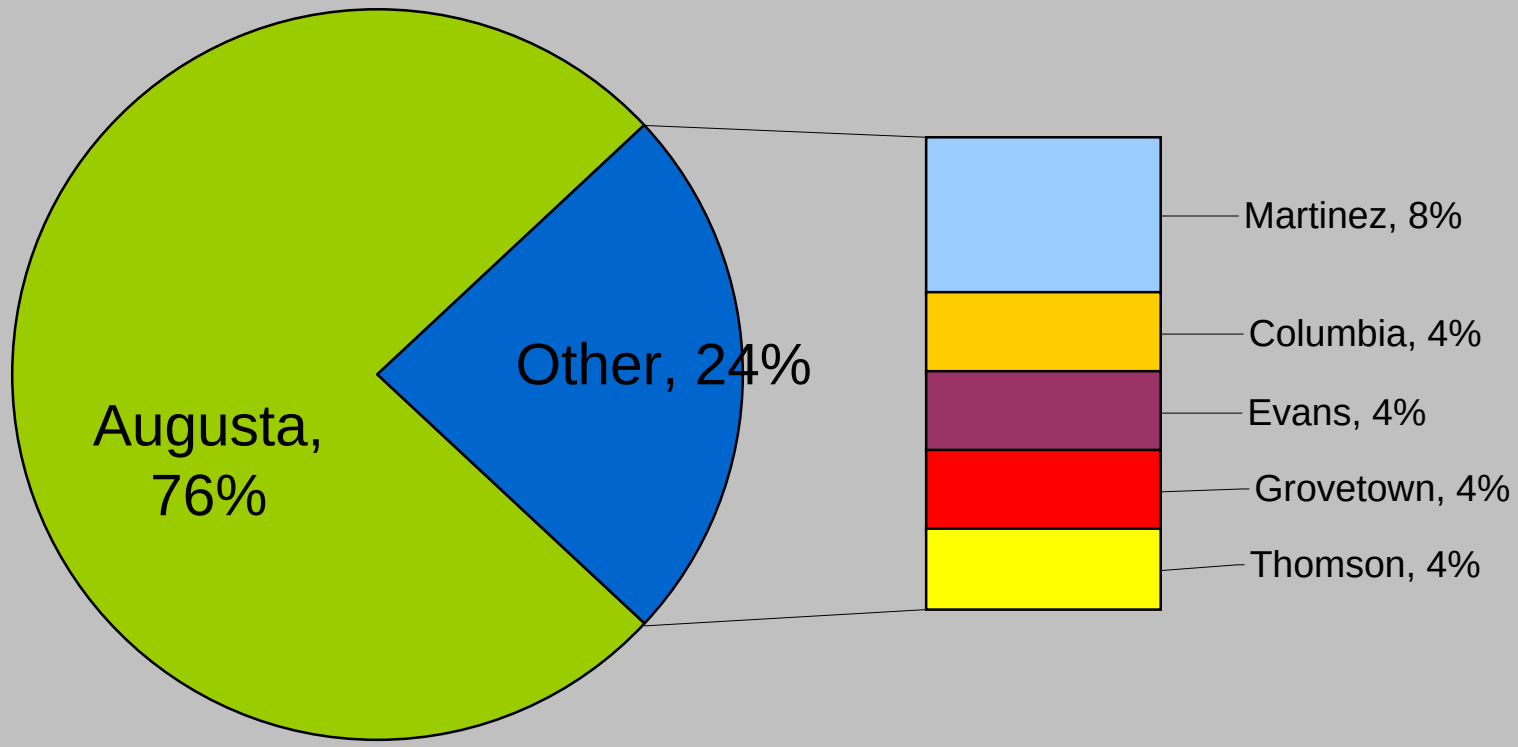


Behavioral Health Link℠

Crisis, Access & Care Management: A Service of Integrated Health Resources

National Suicide Lines FY2005 -- East Central Cities

Behavioral Health Link Crisis & Access Health Call Center

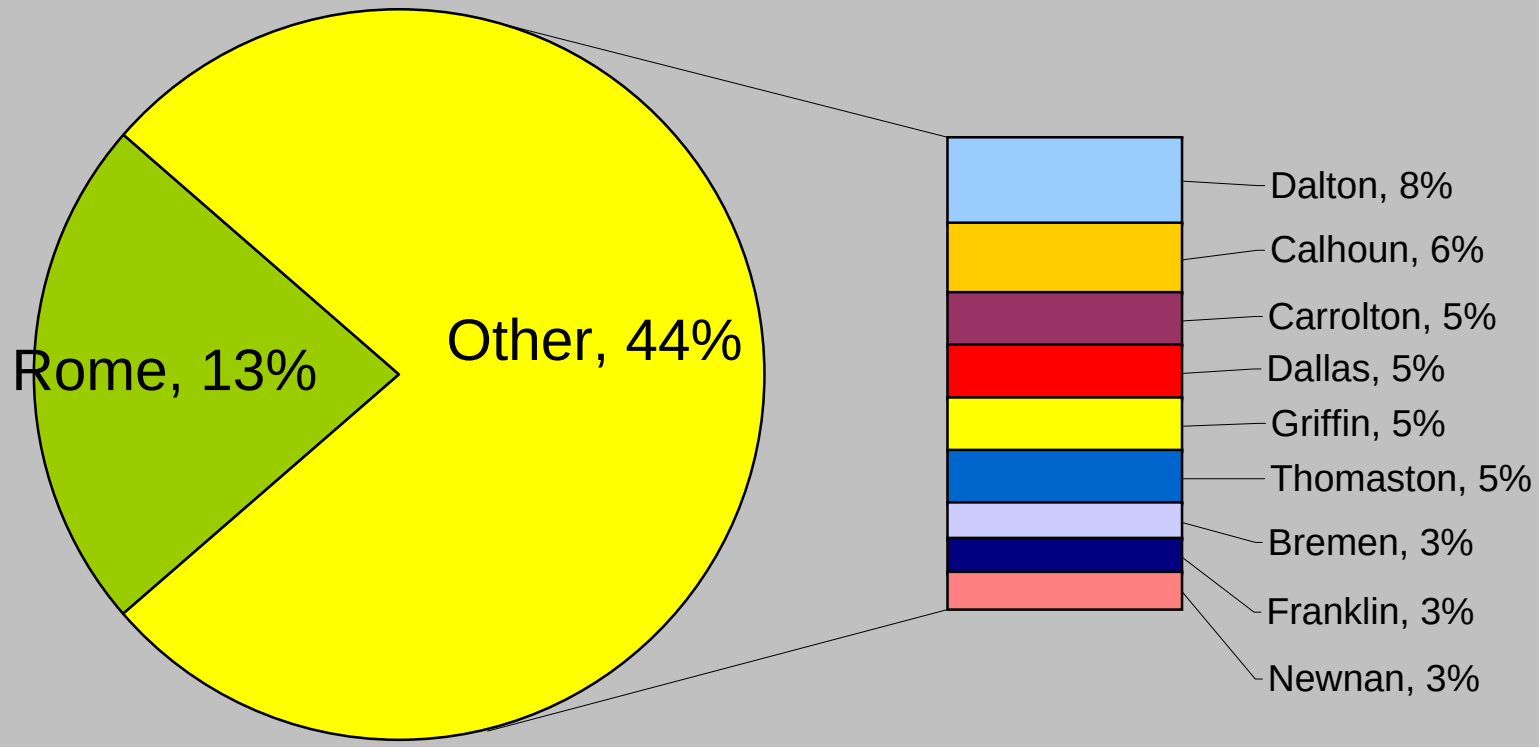


Behavioral Health Link℠

Crisis, Access & Care Management: A Service of Integrated Health Resources

National Suicide Lines FY2005 -- North Region Cities (#1)

Behavioral Health Link Crisis & Access Health Call Center

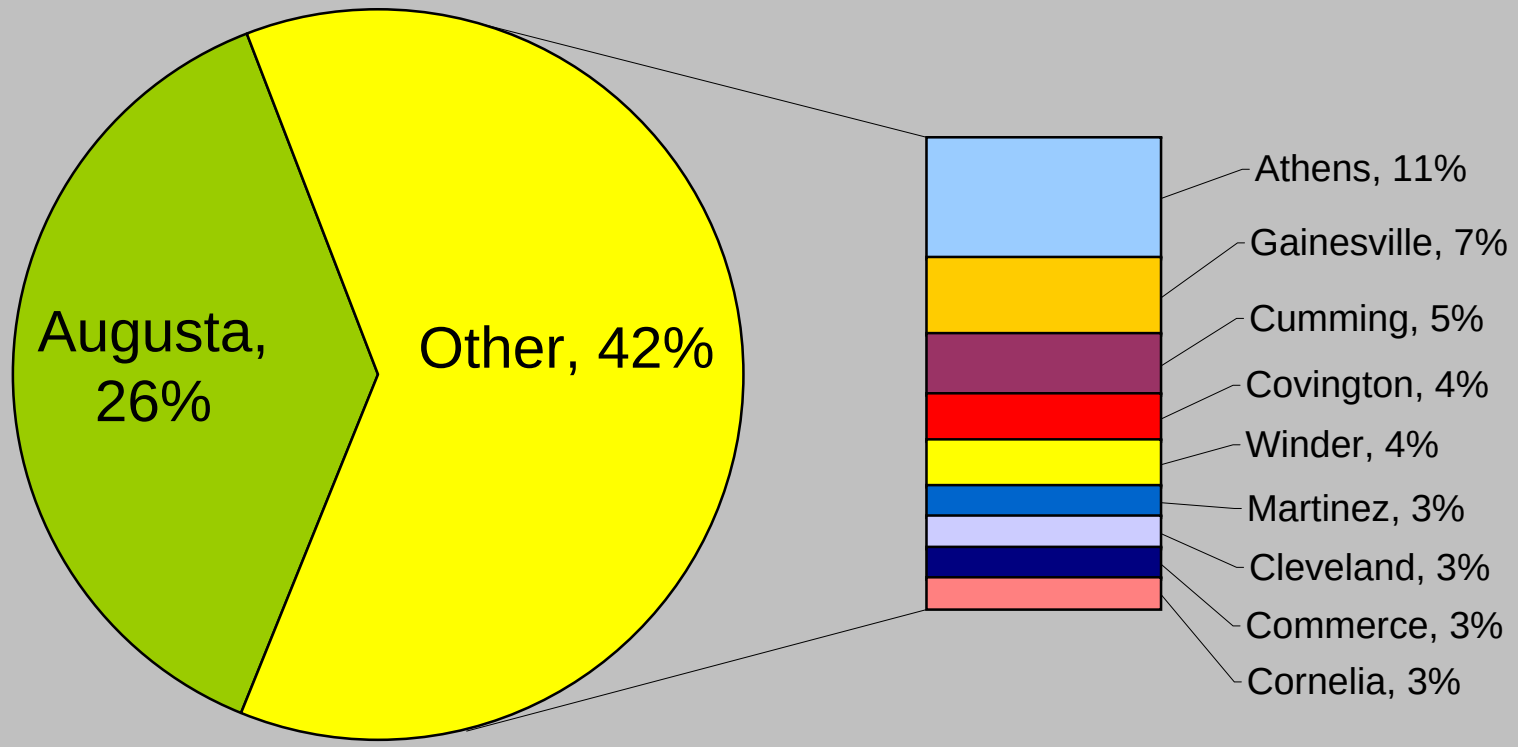


Behavioral Health Link℠

Crisis, Access & Care Management: A Service of Integrated Health Resources

National Suicide Lines FY2005 -- East Central Region Cities (#2)

Behavioral Health Link Crisis & Access Health Call Center

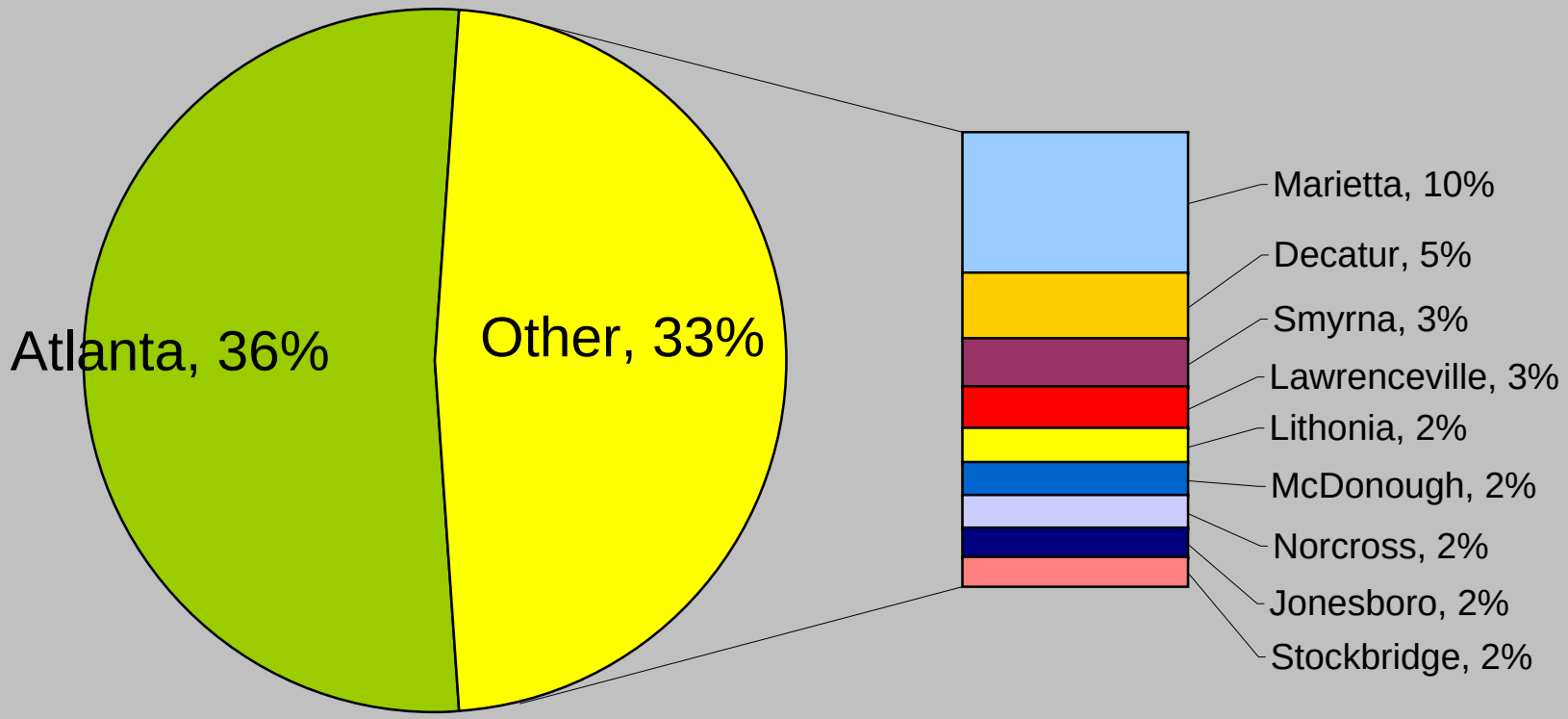


Behavioral Health Link℠

Crisis, Access & Care Management: A Service of Integrated Health Resources

National Suicide Lines FY2005 -- Metro Region Cities (#3)

Behavioral Health Link Crisis & Access Health Call Center

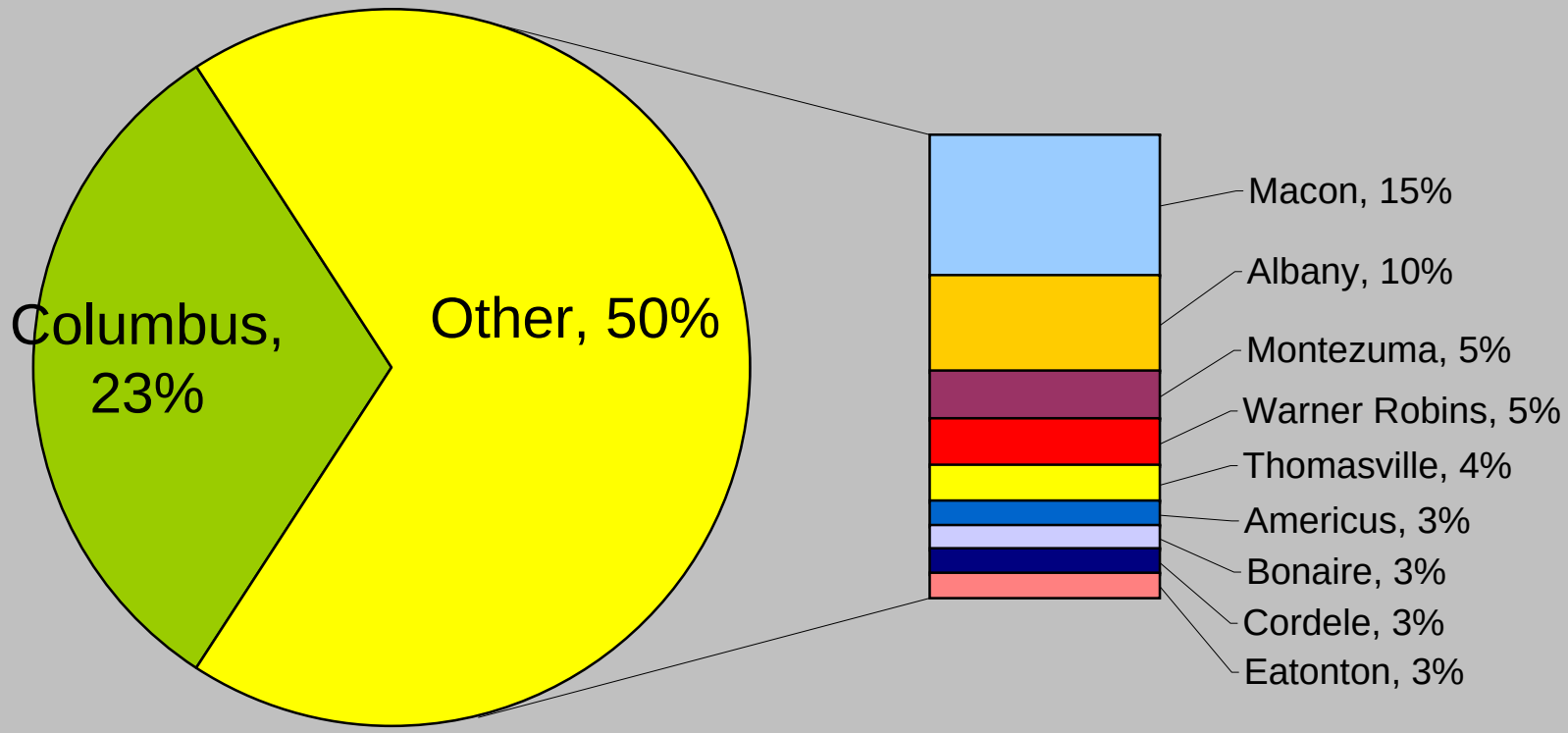


Behavioral Health Link℠

Crisis, Access & Care Management: A Service of Integrated Health Resources

National Suicide Lines FY2005 -- Southwest Region Cities (#4)

Behavioral Health Link Crisis & Access Health Call Center

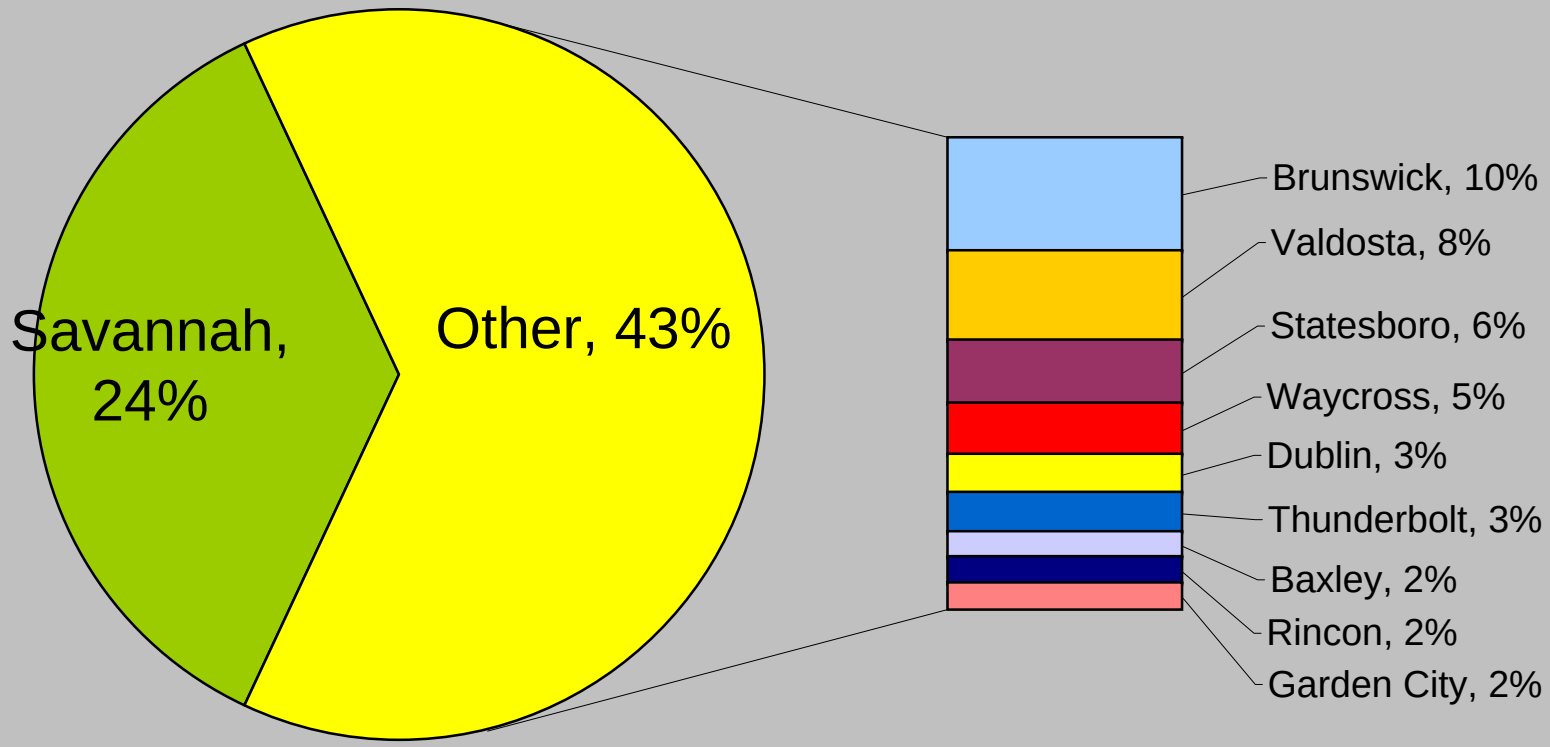


Behavioral Health Link℠

Crisis, Access & Care Management: A Service of Integrated Health Resources

National Suicide Lines FY2005 -- Southeast Region Cities (#5)

Behavioral Health Link Crisis & Access Health Call Center

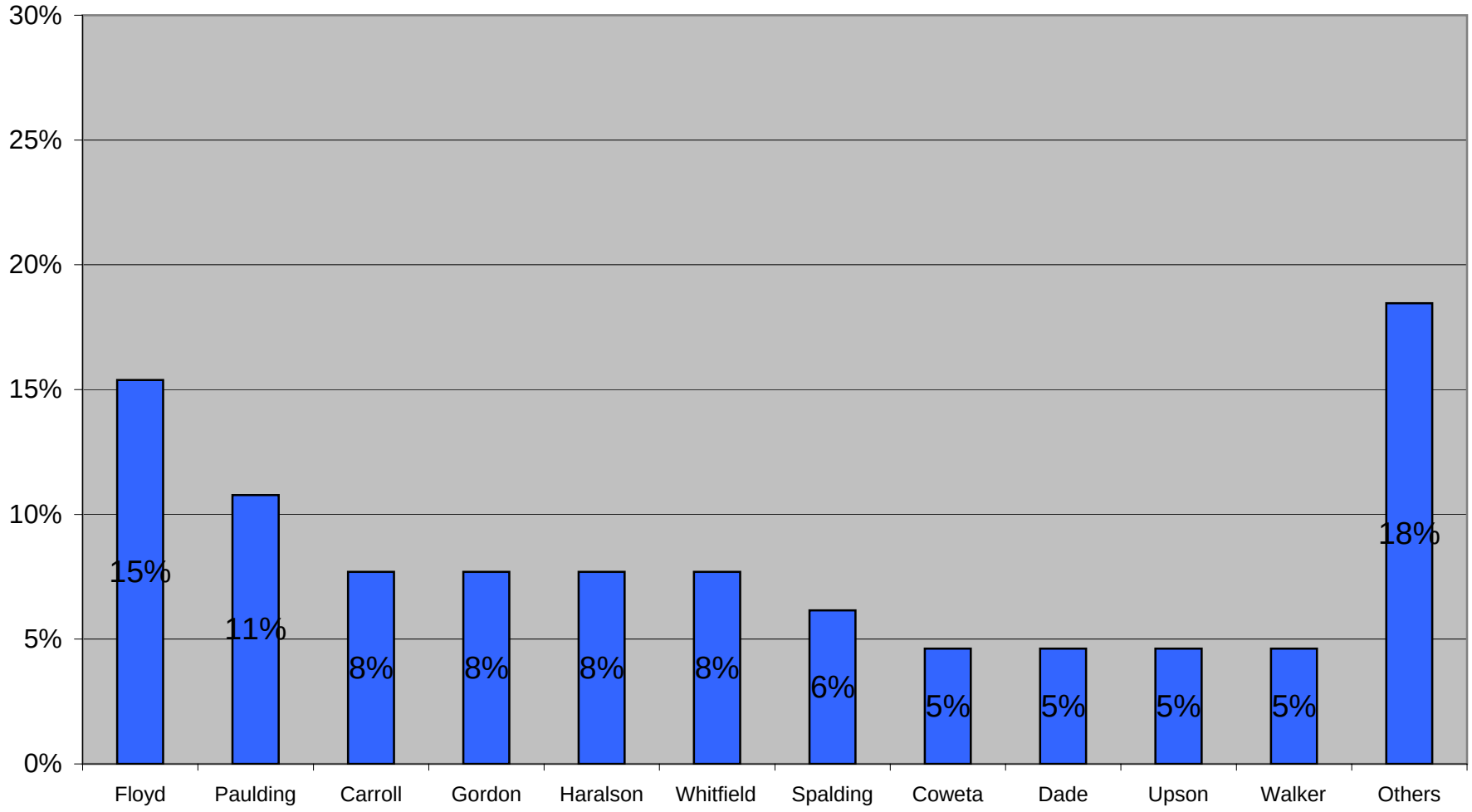


Behavioral Health Link℠

Crisis, Access & Care Management: A Service of Integrated Health Resources

National Suicide Lines FY2005 -- North Region Counties (#1)

Behavioral Health Link Crisis & Access Health Call Center

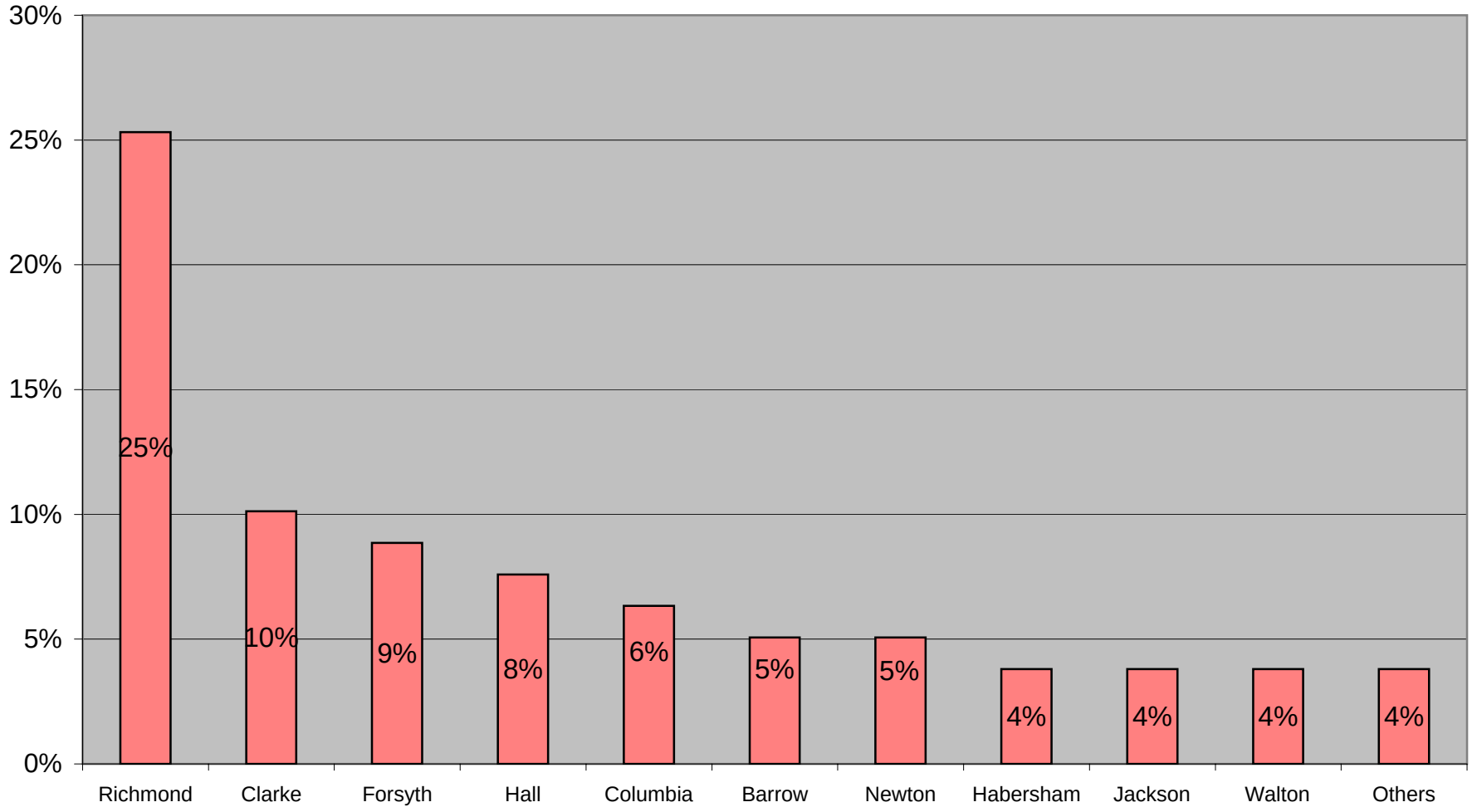


Behavioral Health Link℠

Crisis, Access & Care Management: A Service of Integrated Health Resources

National Suicide Lines FY2005 -- East Central Region Counties (#2)

Behavioral Health Link Crisis & Access Health Call Center

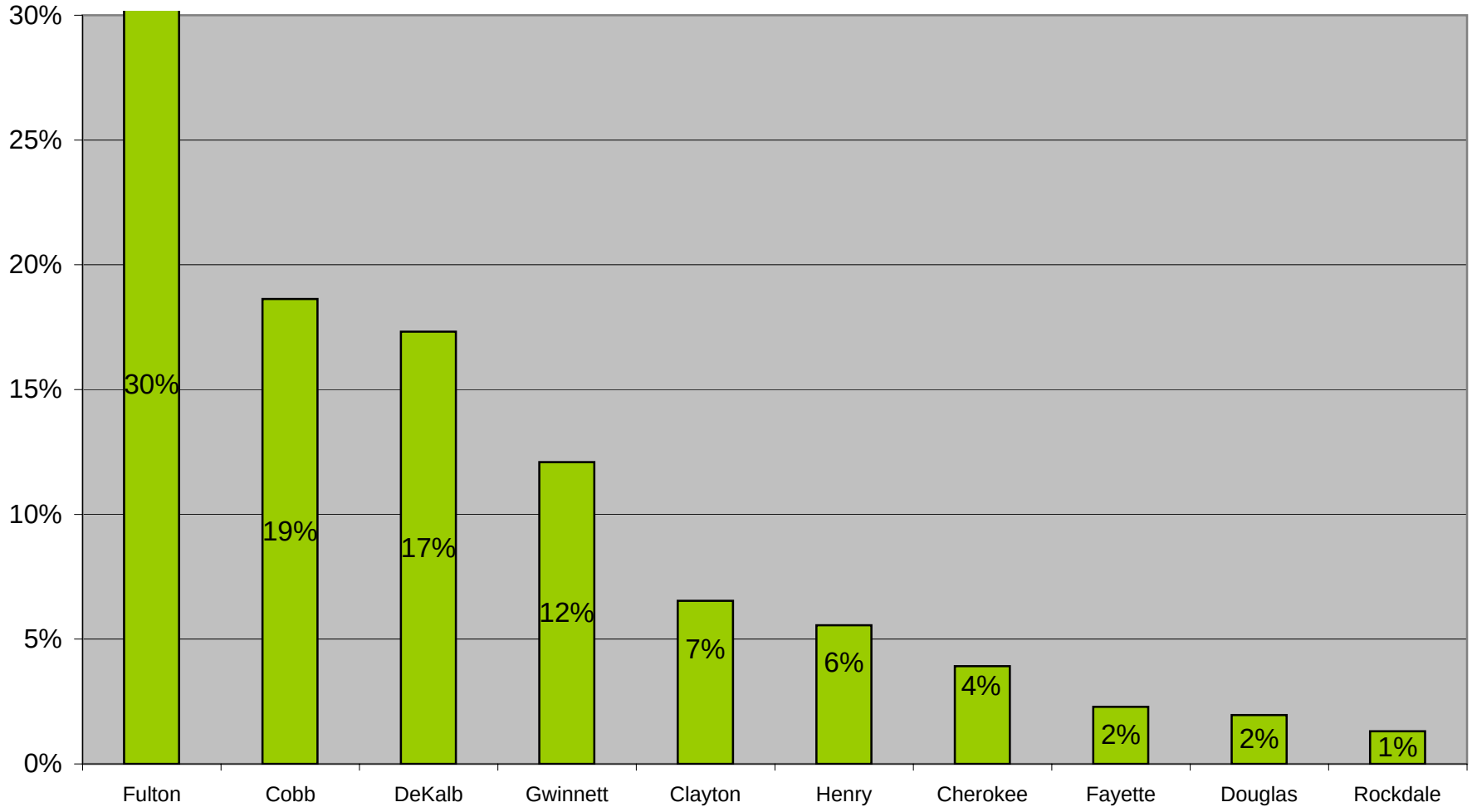


Behavioral Health Link℠

Crisis, Access & Care Management: A Service of Integrated Health Resources

National Suicide Lines FY2005 -- Metro Region Counties (#3)

Behavioral Health Link Crisis & Access Health Call Center

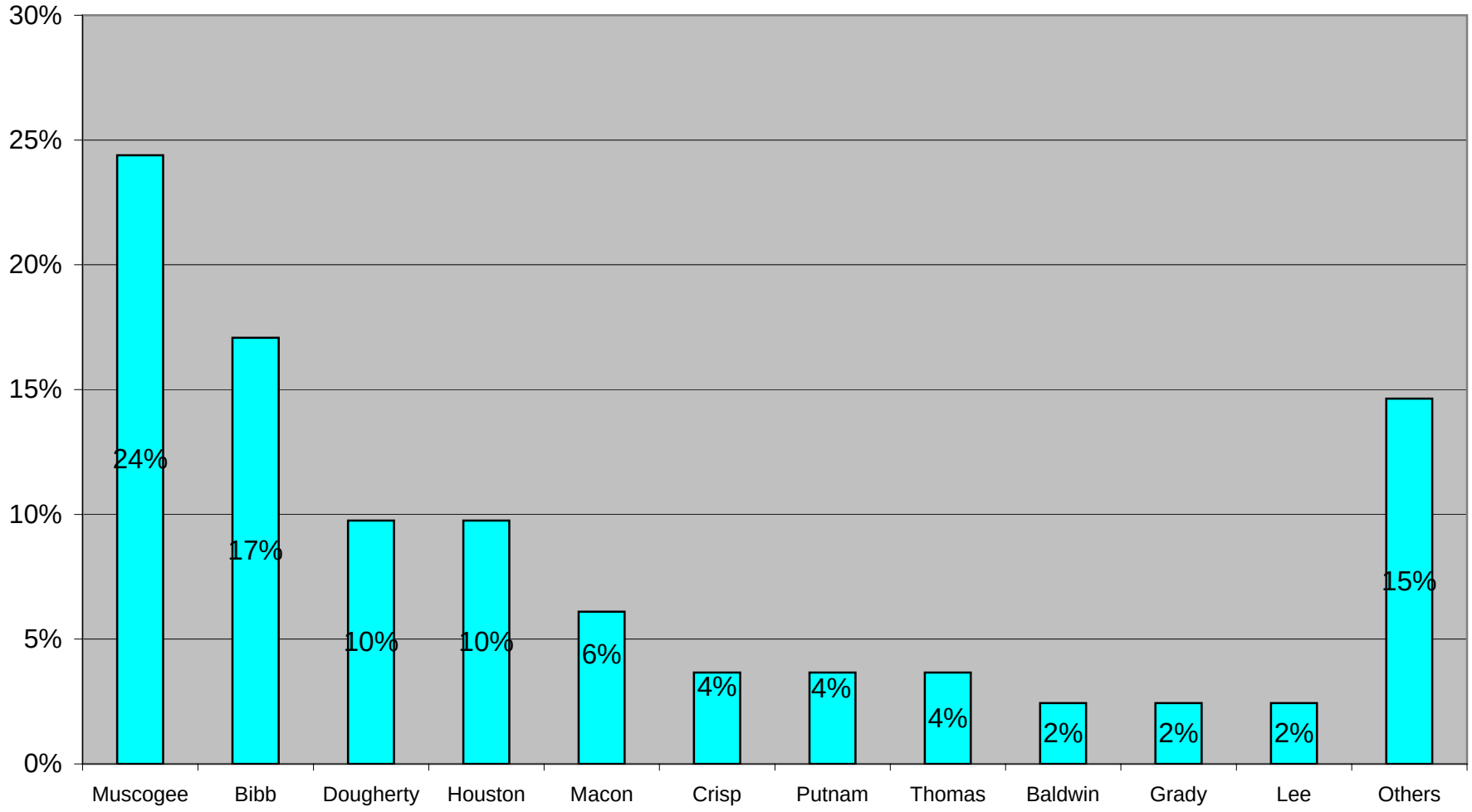


Behavioral Health Link℠

Crisis, Access & Care Management: A Service of Integrated Health Resources

National Suicide Lines FY2005 -- Southwest Region Counties (#4)

Behavioral Health Link Crisis & Access Health Call Center

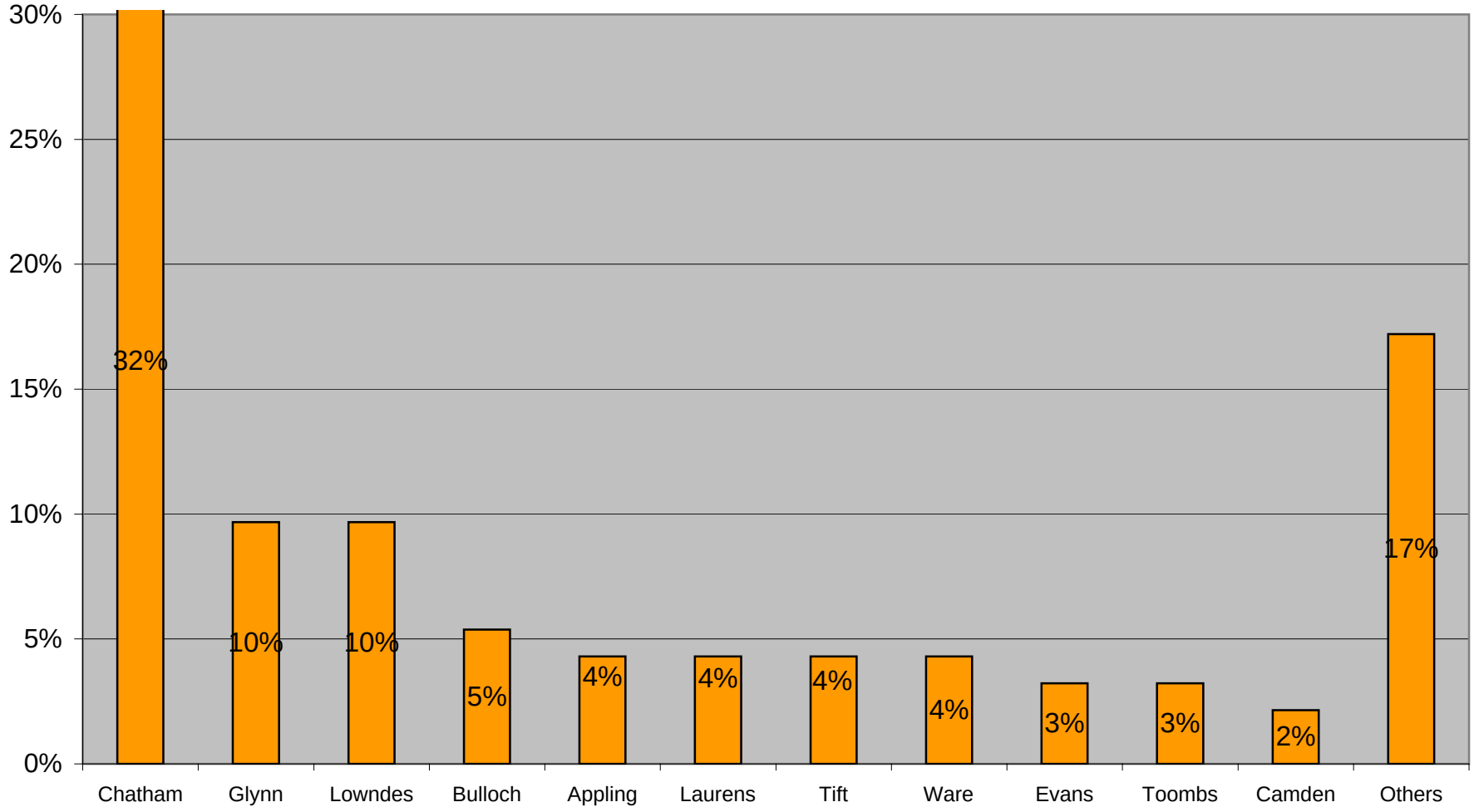


Behavioral Health Link℠

Crisis, Access & Care Management: A Service of Integrated Health Resources

National Suicide Lines FY2005 -- Southeast Region Counties (#5)

Behavioral Health Link Crisis & Access Health Call Center

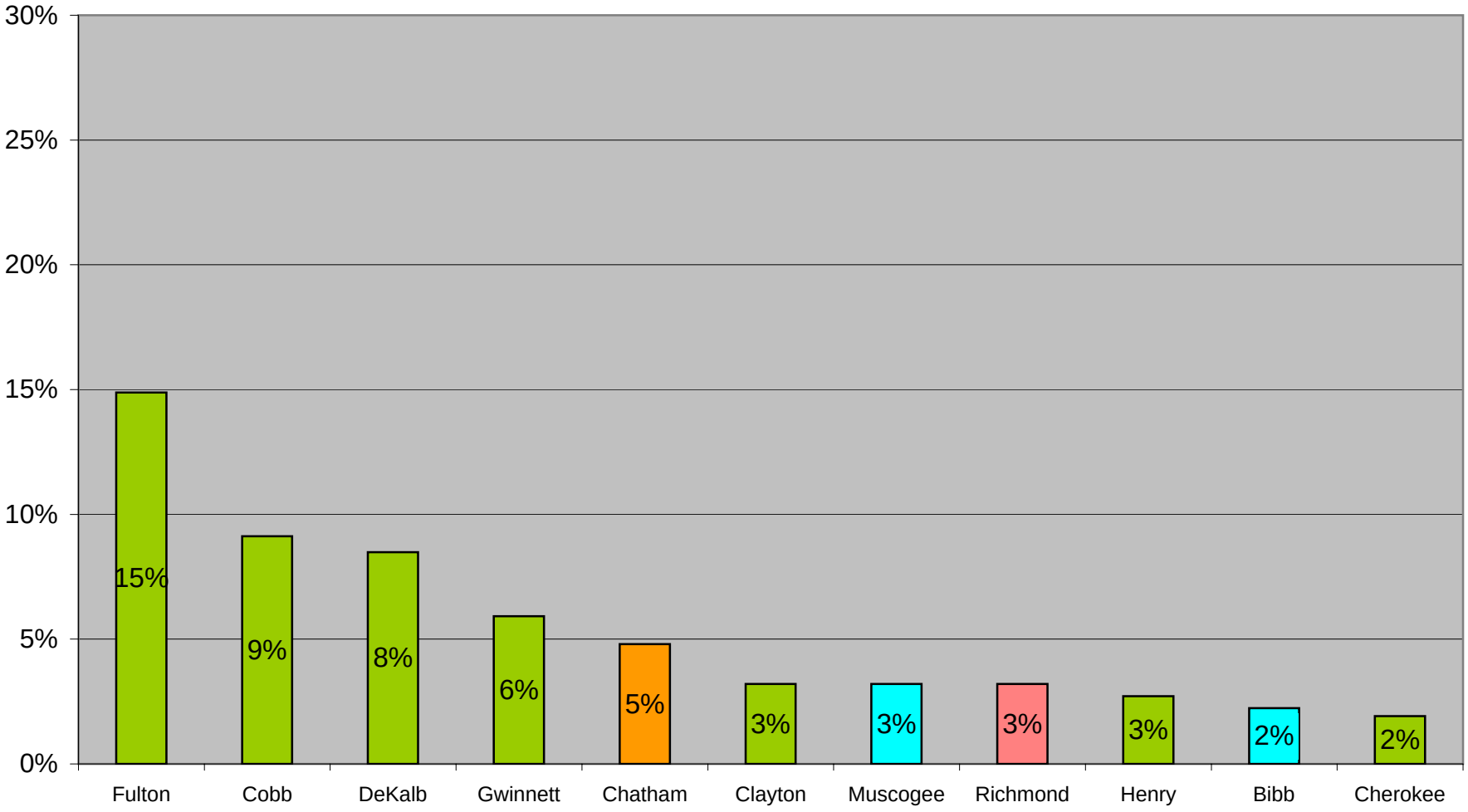


Behavioral Health Link℠

Crisis, Access & Care Management: A Service of Integrated Health Resources

National Suicide Lines FY2005 -- Top Georgia Counties

Behavioral Health Link Crisis & Access Health Call Center

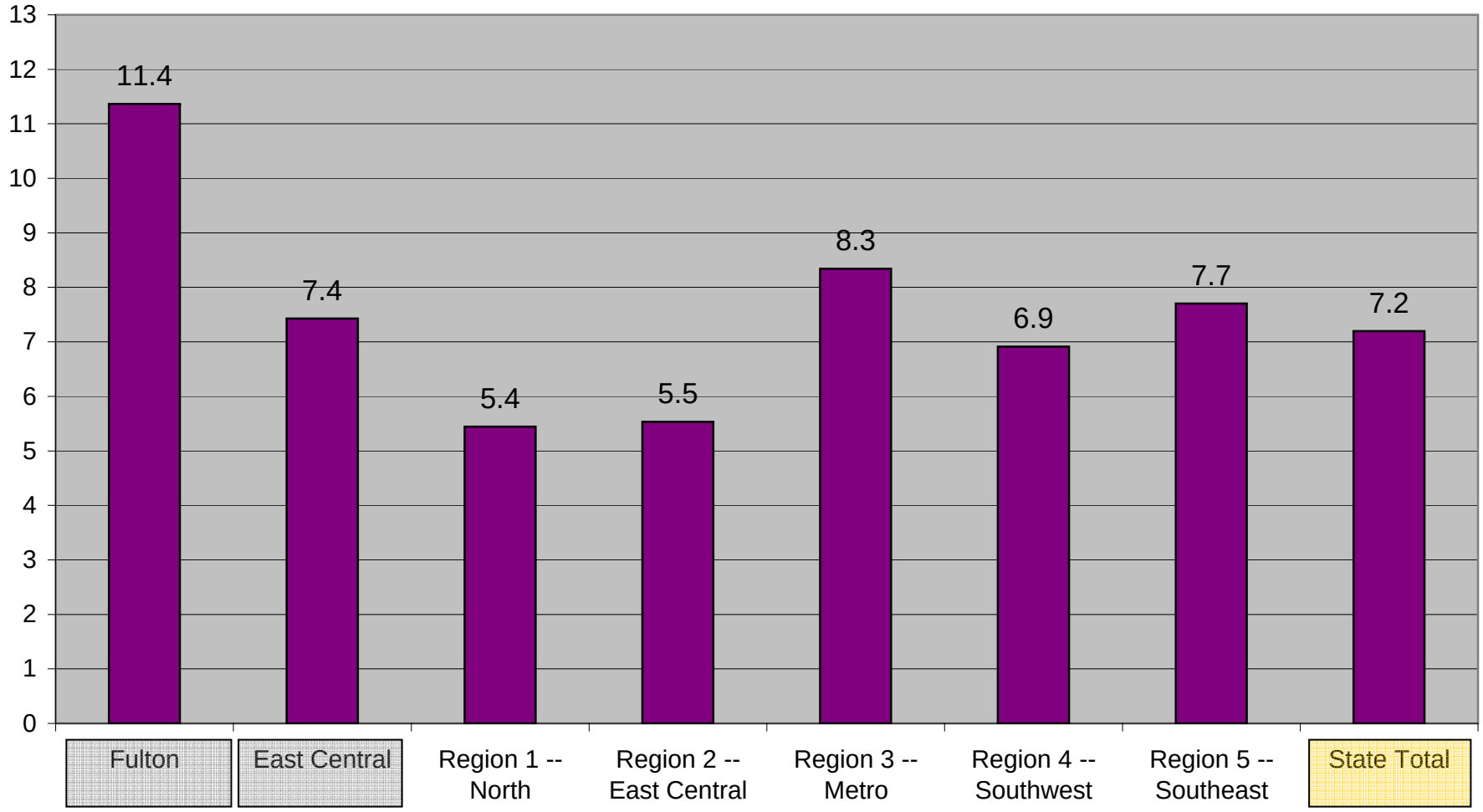


Behavioral Health Link℠

Crisis, Access & Care Management: A Service of Integrated Health Resources

National Suicide Lines FY2005 -- Overall Market Penetration (Cases Per 100,000)

Behavioral Health Link Crisis & Access Health Call Center

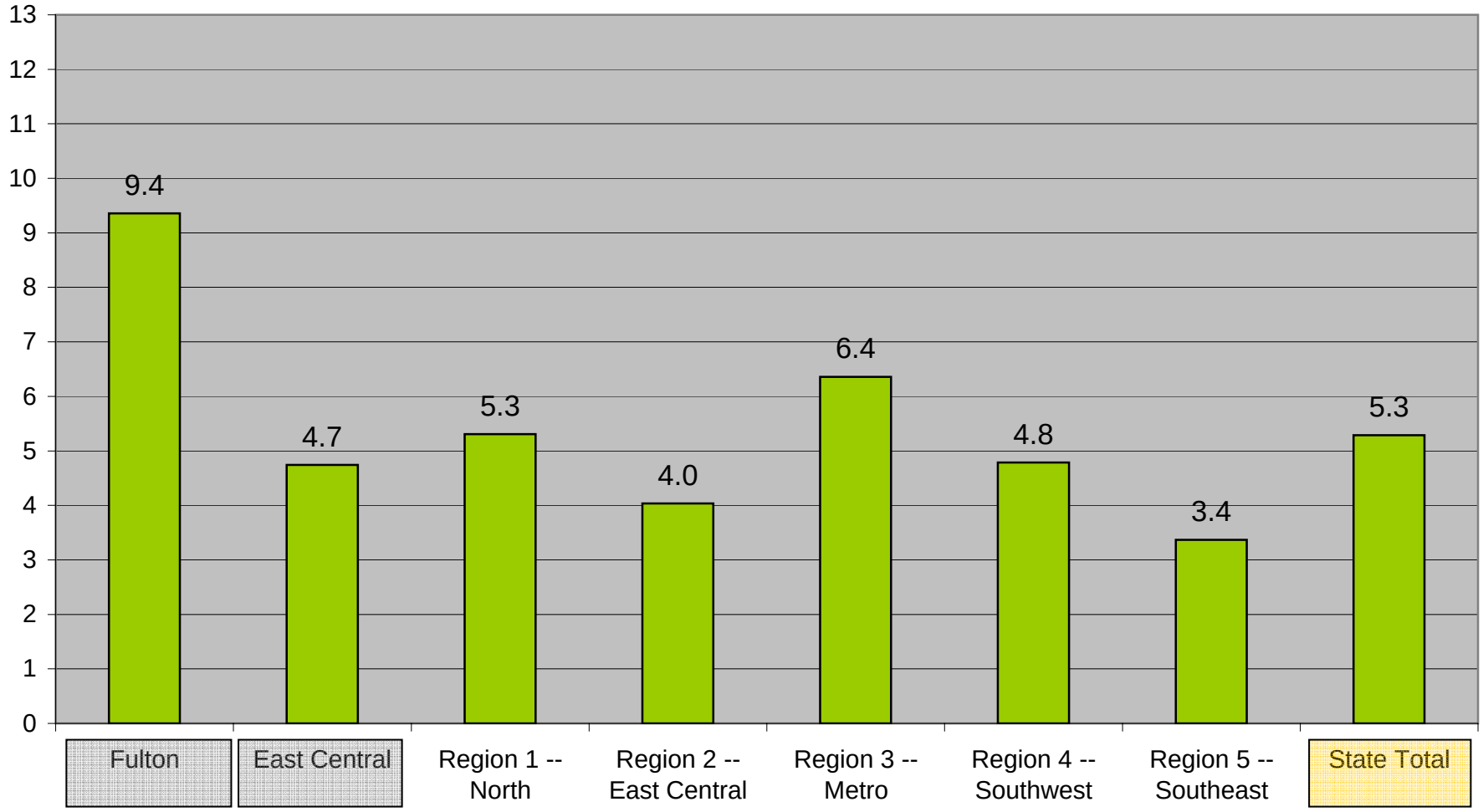


Behavioral Health Link℠

Crisis, Access & Care Management: A Service of Integrated Health Resources

National Suicide Lines FY2005 -- African American Market Penetration (Cases Per 100,000)

Behavioral Health Link Crisis & Access Health Call Center

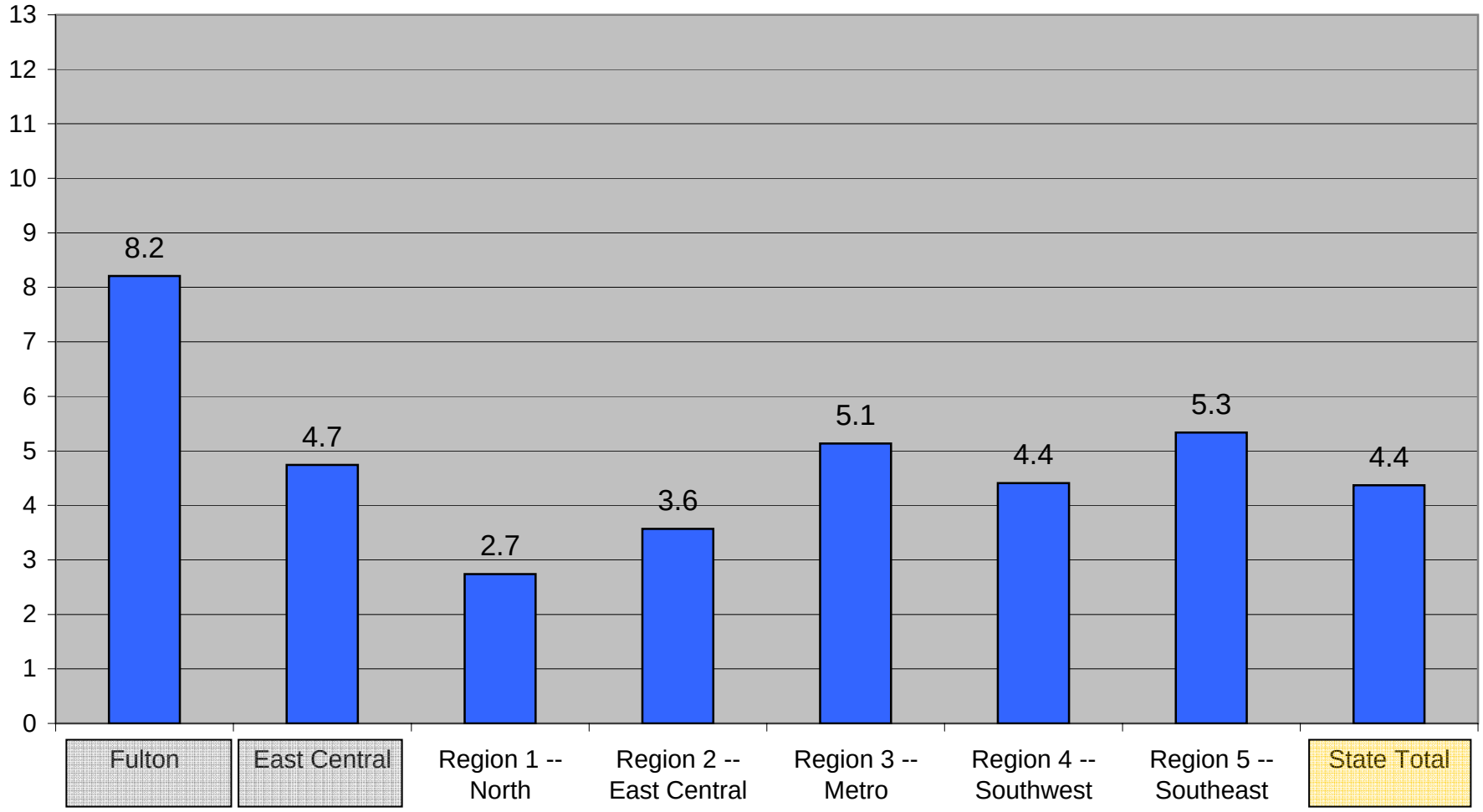


Behavioral Health Link℠

Crisis, Access & Care Management: A Service of Integrated Health Resources

National Suicide Lines FY2005 -- Caucasian Market Penetration (Cases Per 100,000)

Behavioral Health Link Crisis & Access Health Call Center

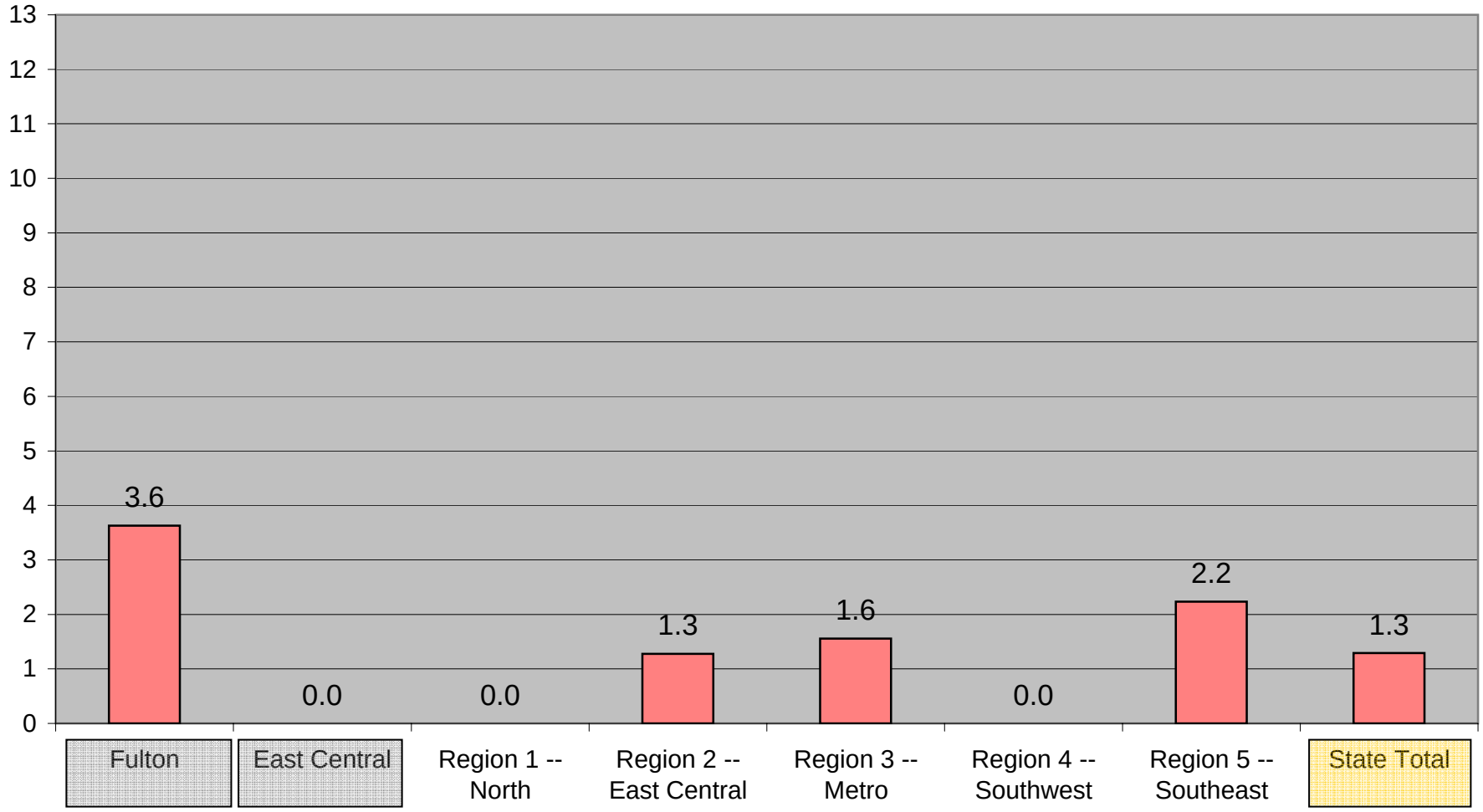


Behavioral Health Link℠

Crisis, Access & Care Management: A Service of Integrated Health Resources

National Suicide Lines FY2005 -- Hispanic Market Penetration (Cases Per 100,000)

Behavioral Health Link Crisis & Access Health Call Center

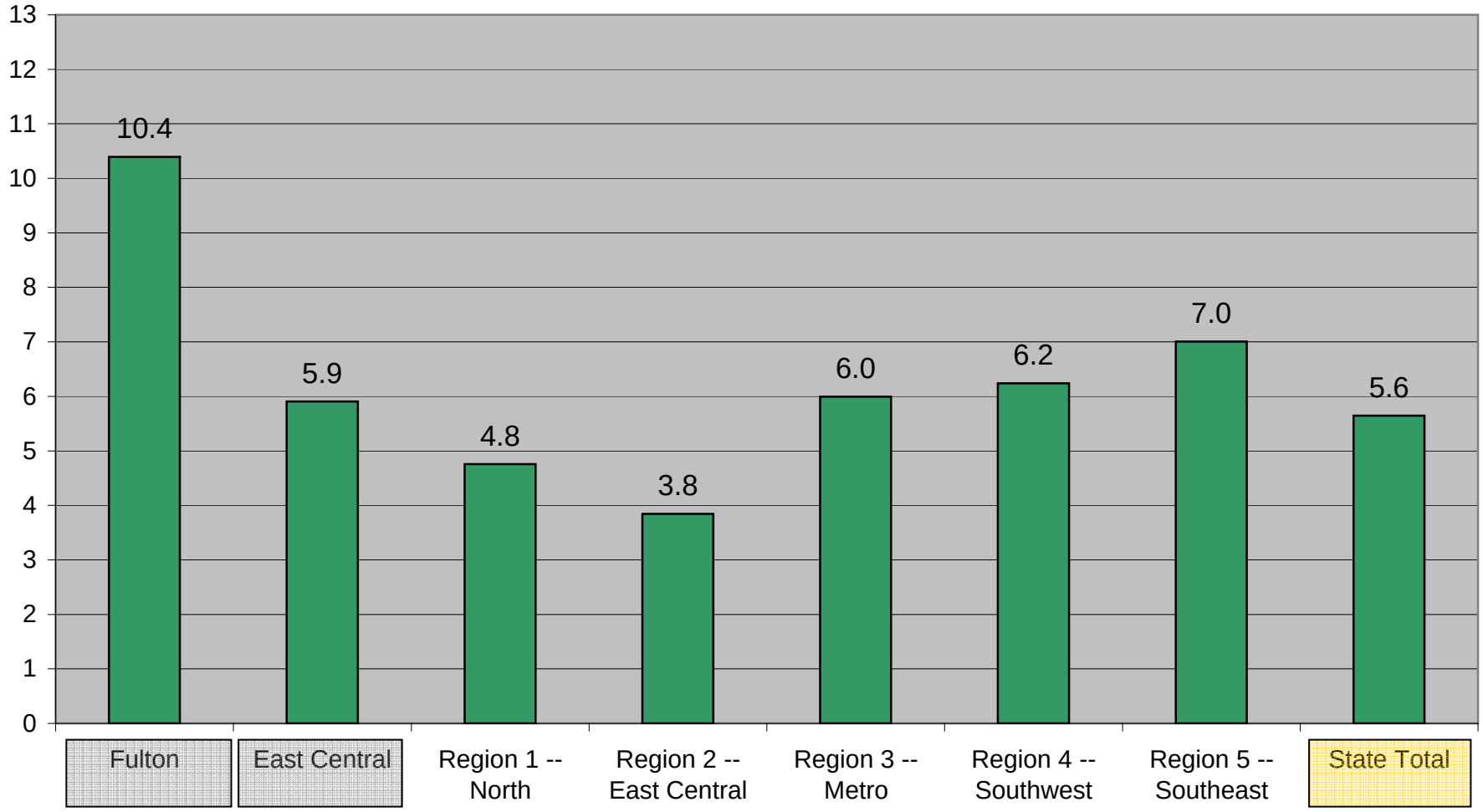


Behavioral Health Link℠

Crisis, Access & Care Management: A Service of Integrated Health Resources

National Suicide Lines FY2005 -- Market Penetration
Males (Cases Per 100,000)

Behavioral Health Link Crisis & Access Health Call Center

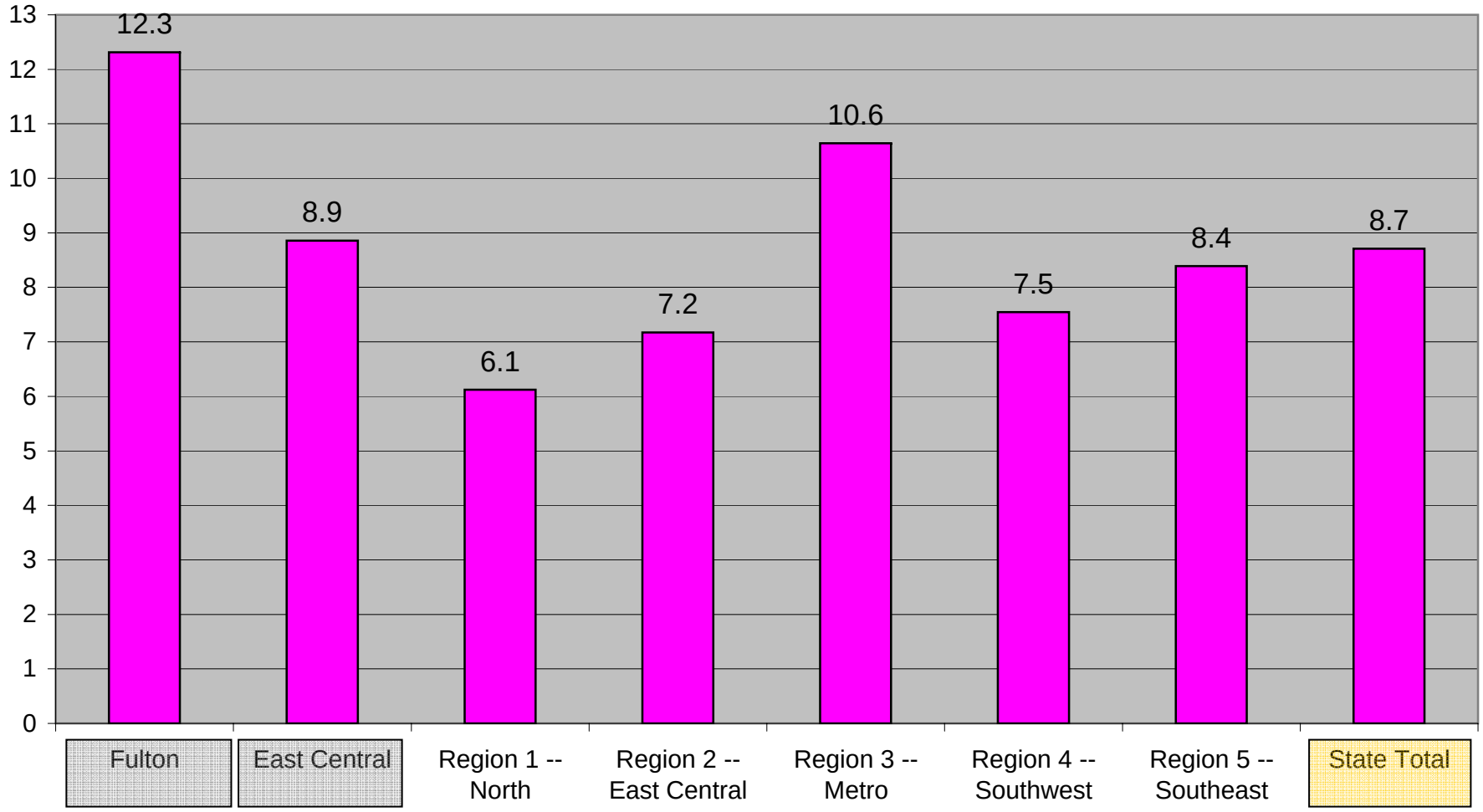


Behavioral Health Link℠

Crisis, Access & Care Management: A Service of Integrated Health Resources

National Suicide Lines FY2005 -- Market Penetration
Females (Cases Per 100,000)

Behavioral Health Link Crisis & Access Health Call Center

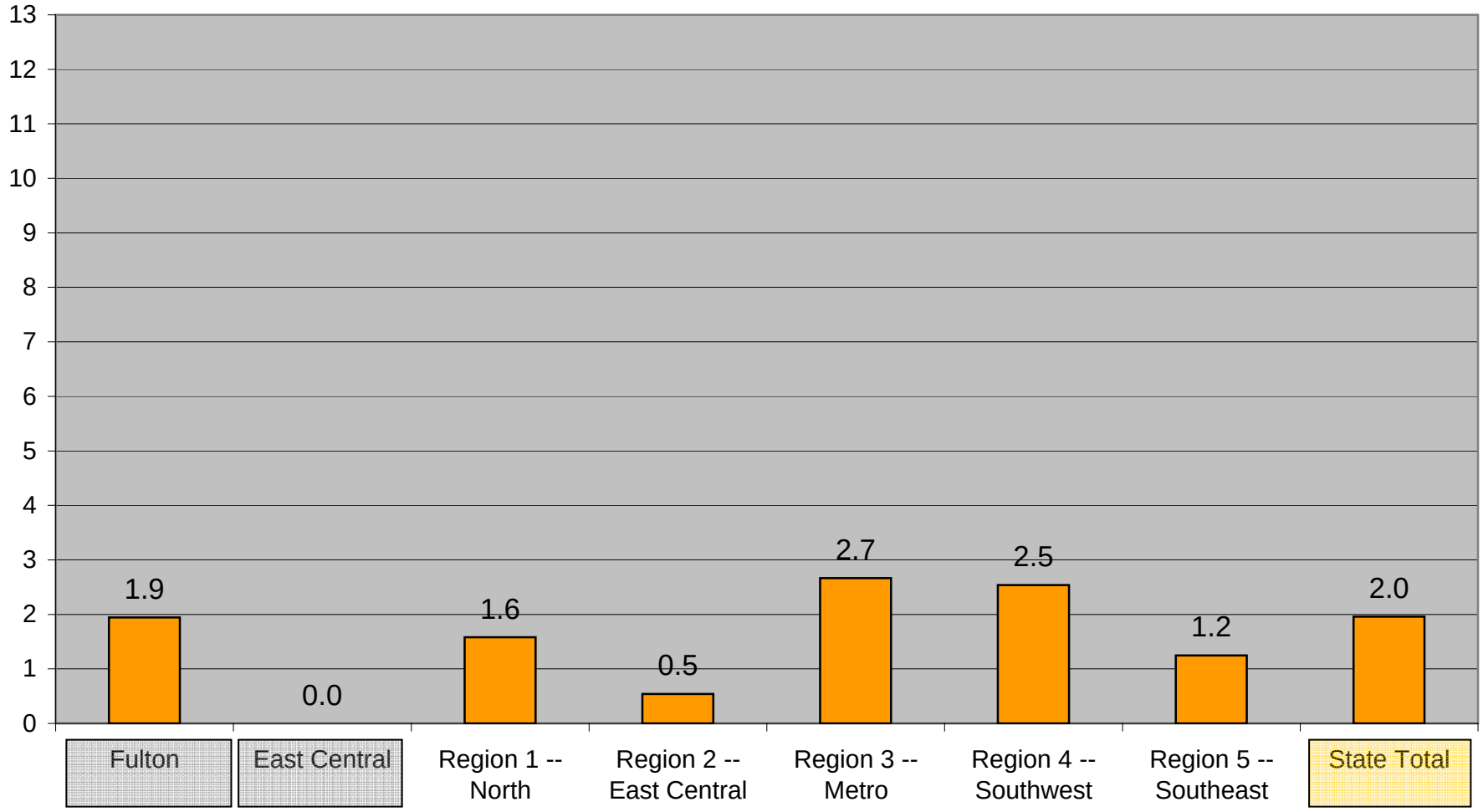


Behavioral Health Link℠

Crisis, Access & Care Management: A Service of Integrated Health Resources

National Suicide Lines FY2005 -- Market Penetration
Under 18 (Cases Per 100,000)

Behavioral Health Link Crisis & Access Health Call Center

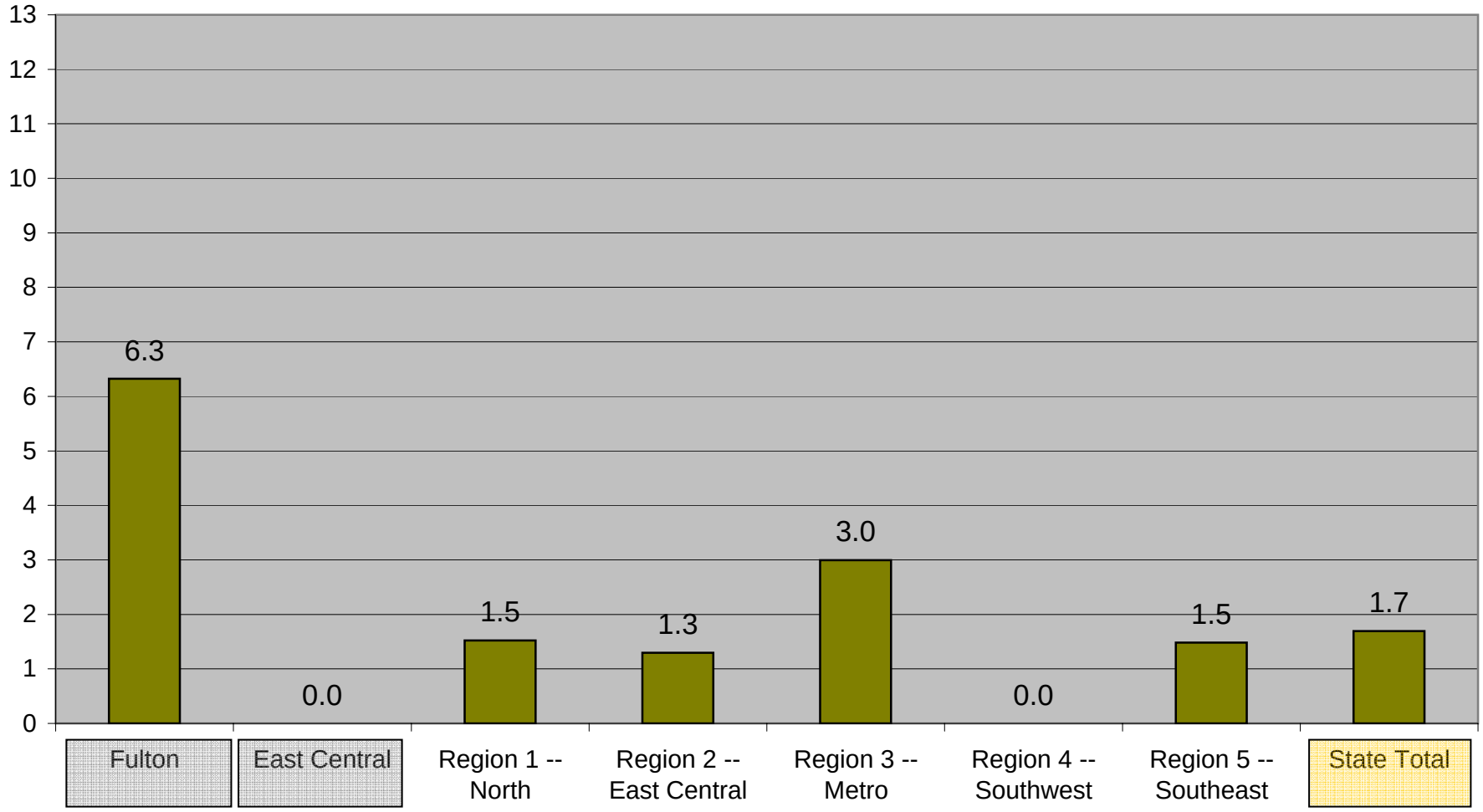


Behavioral Health Link℠

Crisis, Access & Care Management: A Service of Integrated Health Resources

National Suicide Lines FY2005 -- Market Penetration
65 and Over (Cases Per 100,000)

Behavioral Health Link Crisis & Access Health Call Center

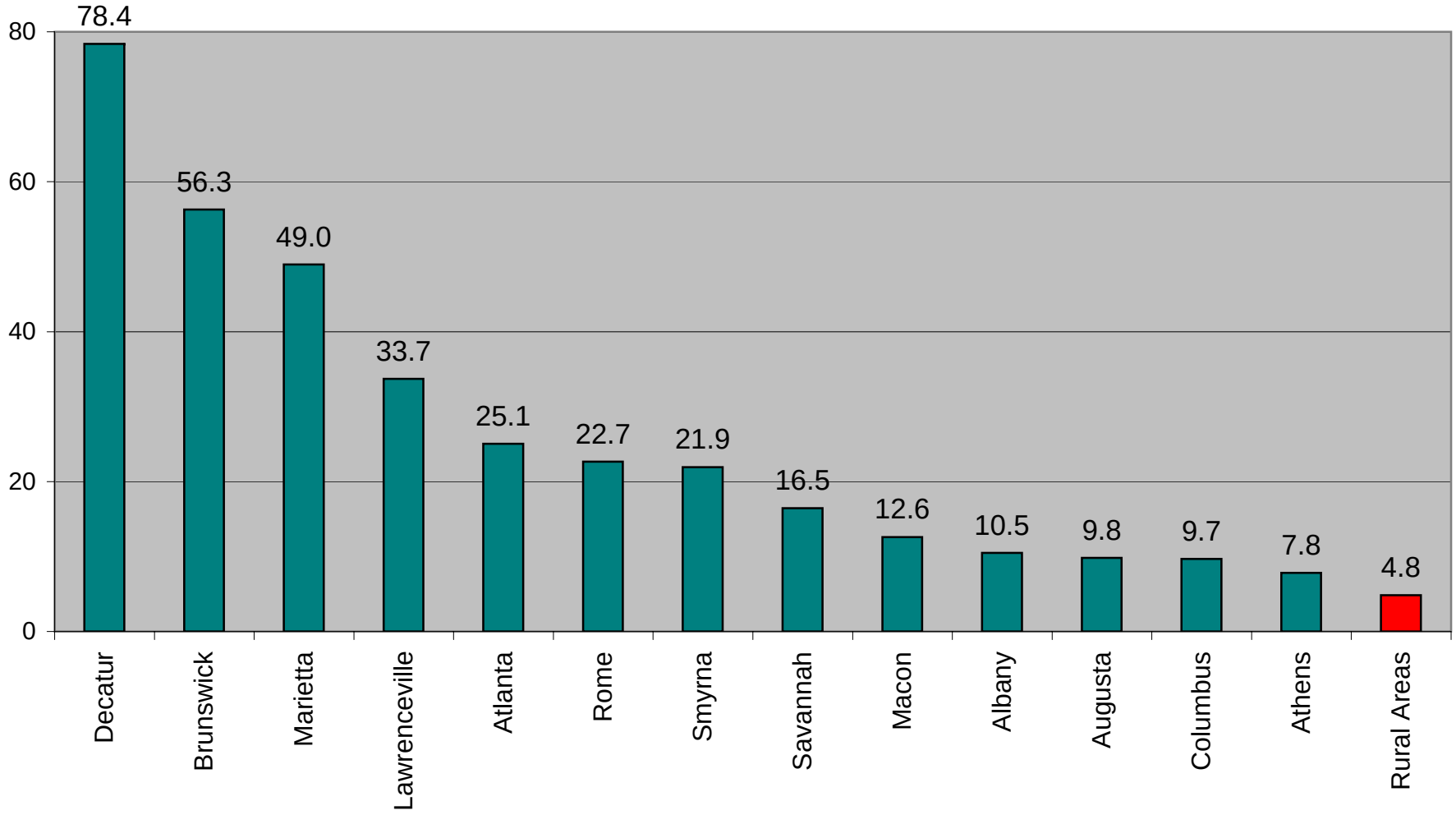


Behavioral Health Link℠

Crisis, Access & Care Management: A Service of Integrated Health Resources

National Suicide Lines FY2005 -- Market Penetration
Top Cities Versus Rural (Cases Per 100,000)

Behavioral Health Link Crisis & Access Health Call Center

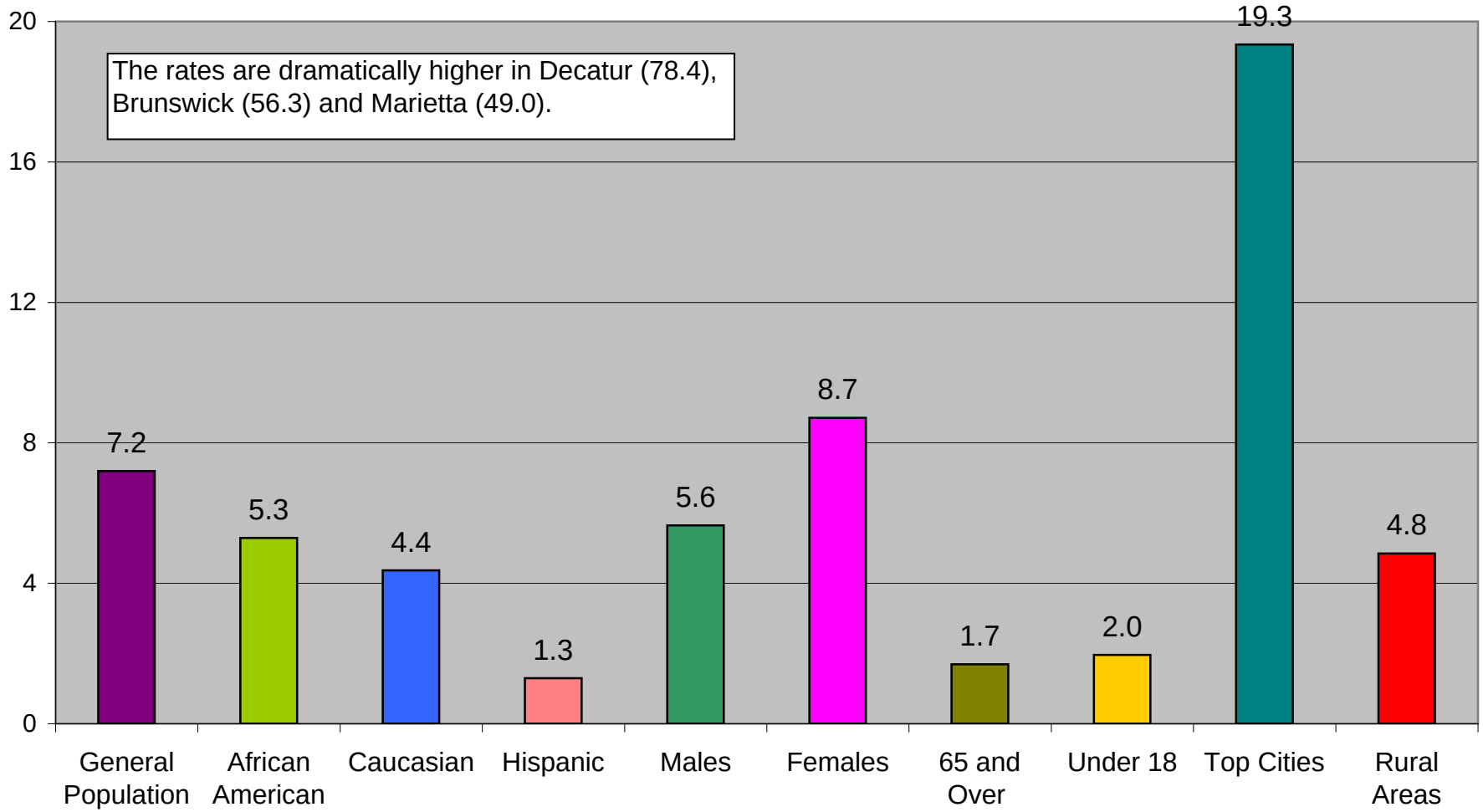


Behavioral Health Link℠

Crisis, Access & Care Management: A Service of Integrated Health Resources

National Suicide Lines FY2005 -- Market Penetration Summary (Cases Per 100,000)

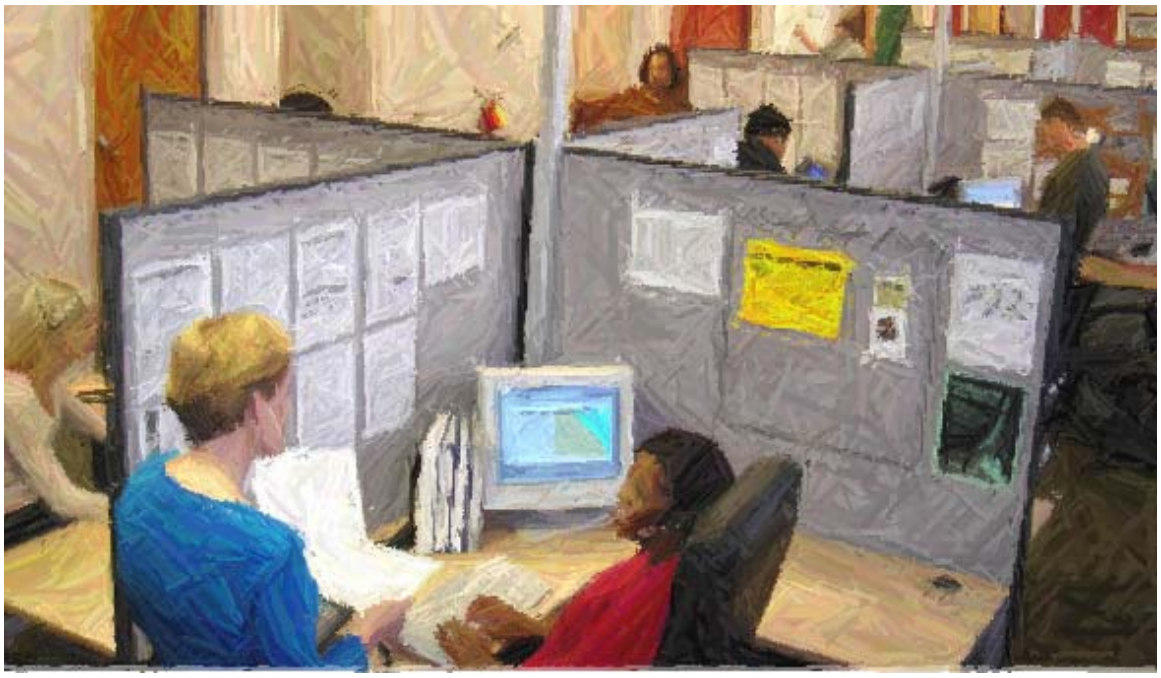
Behavioral Health Link Crisis & Access Health Call Center



Behavioral Health Link℠

Crisis, Access & Care Management: A Service of Integrated Health Resources

Suicide Prevention Hotlines



Section III

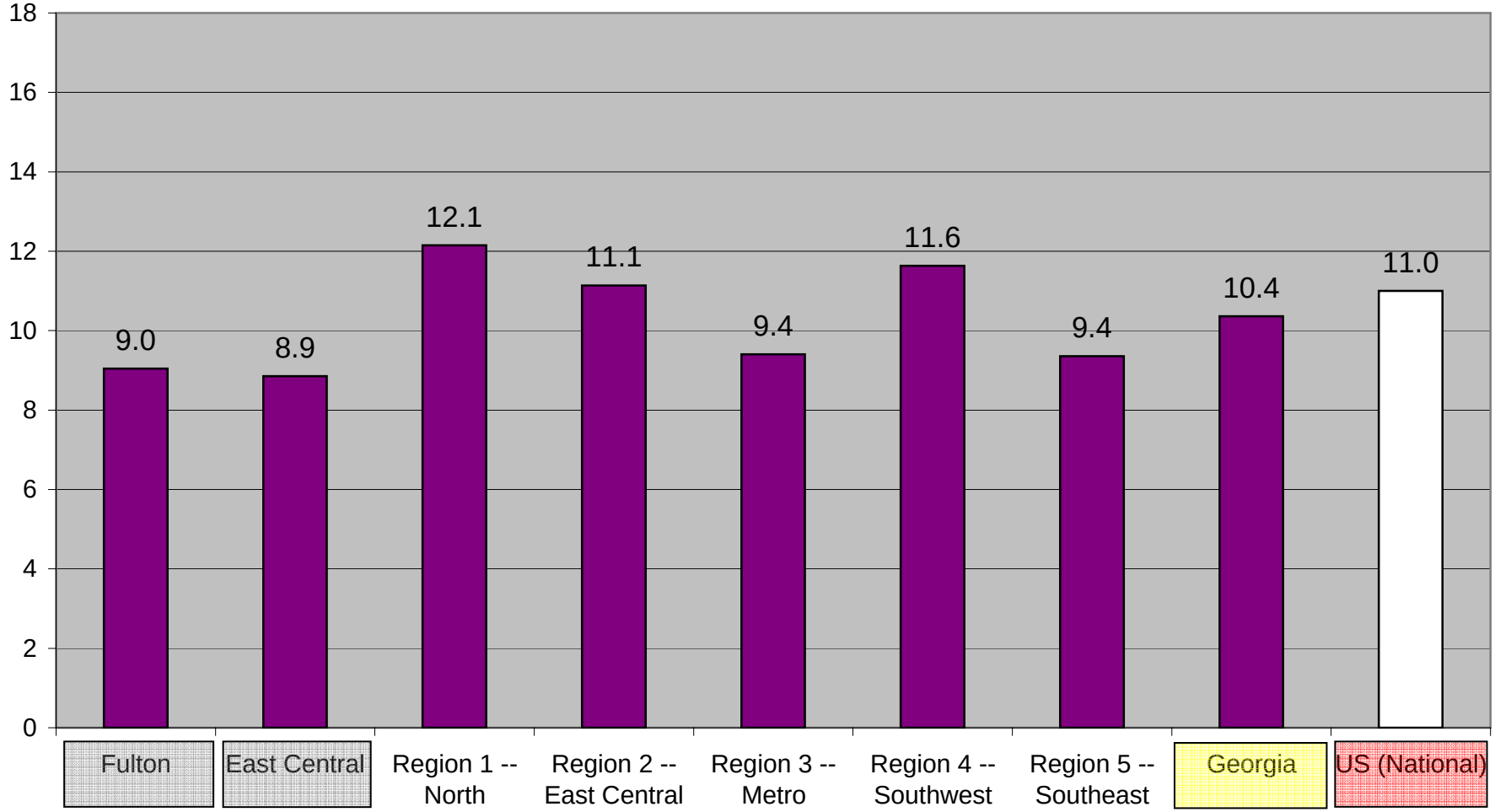
Georgia Suicide Rates

NATIONAL SUICIDE PREVENTION LIFELINE™
1-800-273-TALK
www.suicidepreventionlifeline.org

HOPE
1.800.SUICIDE
784.2433

Overall Suicide Rates in Georgia 2002 (Per 100,000)

The Georgia Statistics System

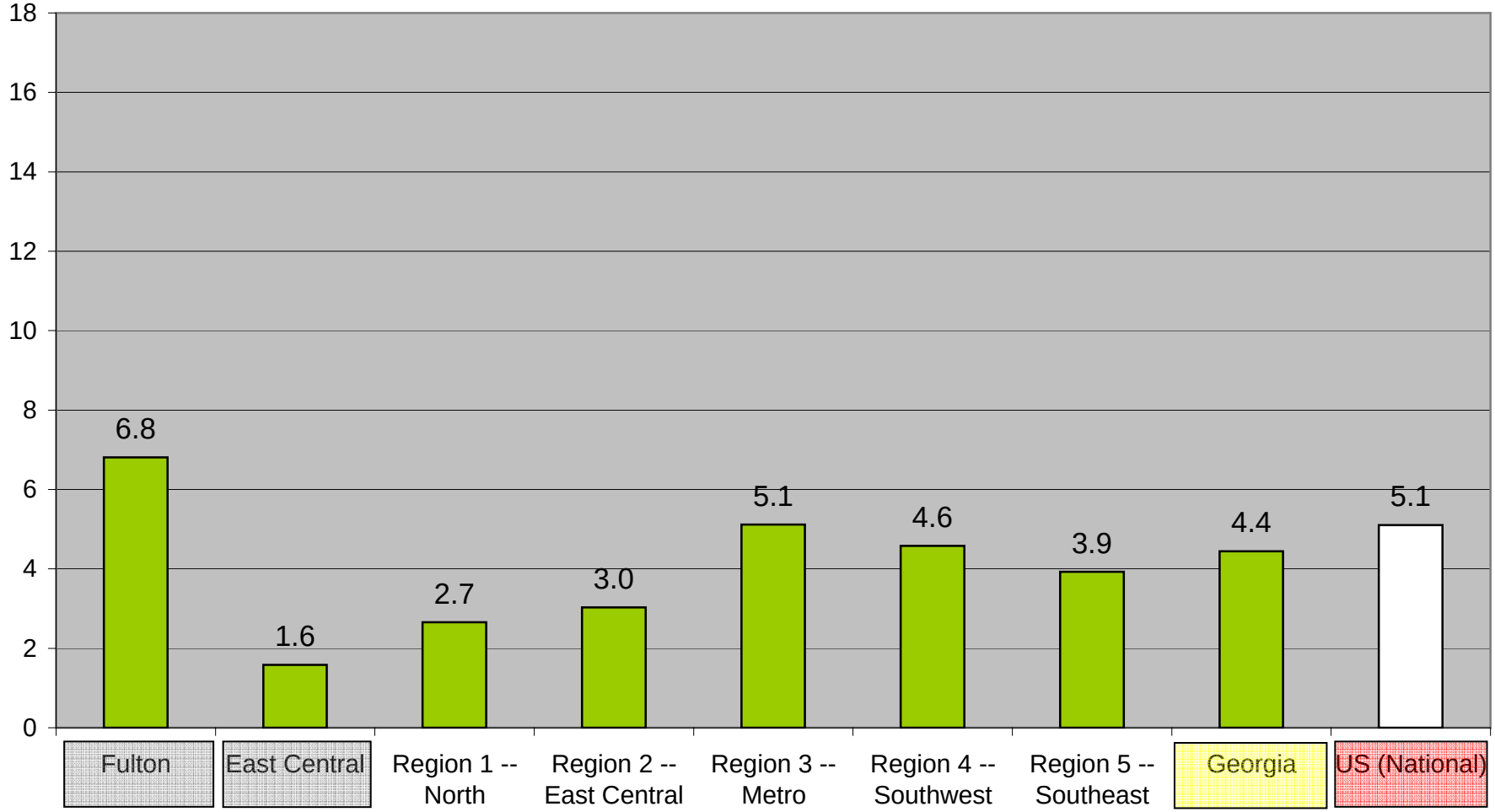


Behavioral Health Link℠

Crisis, Access & Care Management: A Service of Integrated Health Resources

African American Suicide Rates in Georgia 2002 (Per 100,000)

The Georgia Statistics System

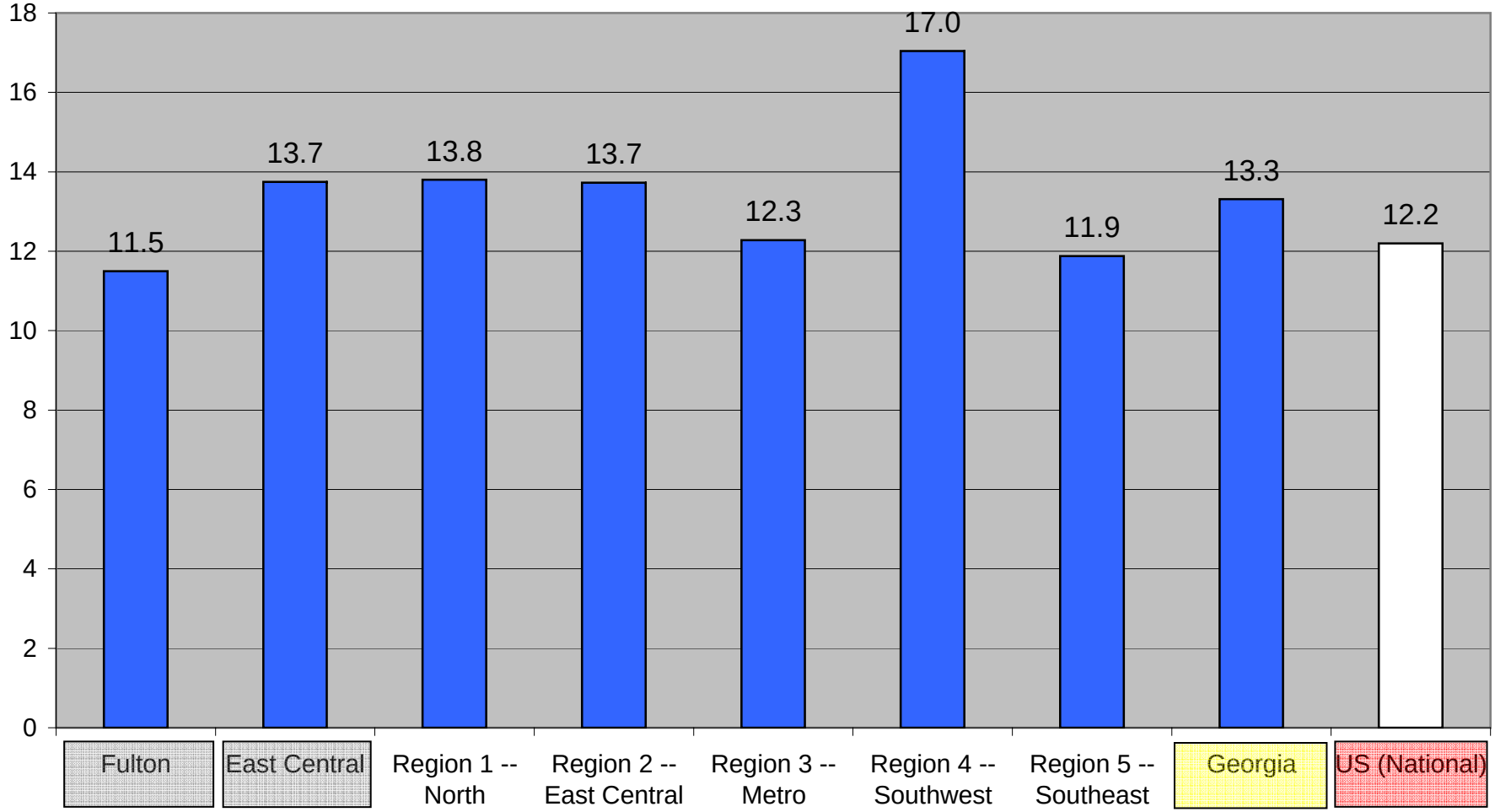


Behavioral Health Link℠

Crisis, Access & Care Management: A Service of Integrated Health Resources

Caucasian Suicide Rates in Georgia 2002 (Per 100,000)

The Georgia Statistics System

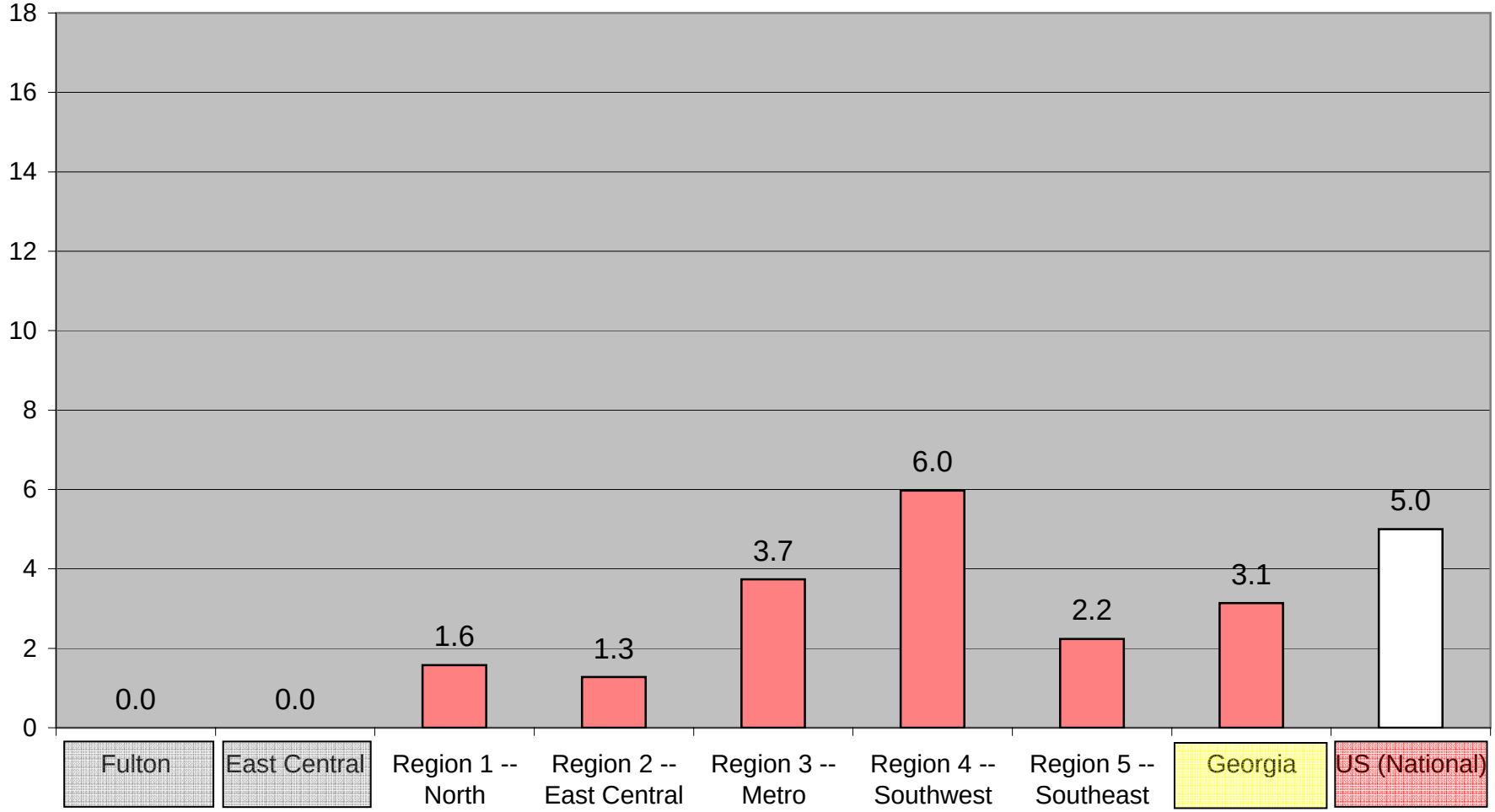


Behavioral Health Link℠

Crisis, Access & Care Management: A Service of Integrated Health Resources

Hispanic Suicide Rates in Georgia 2002 (Per 100,000)

The Georgia Statistics System

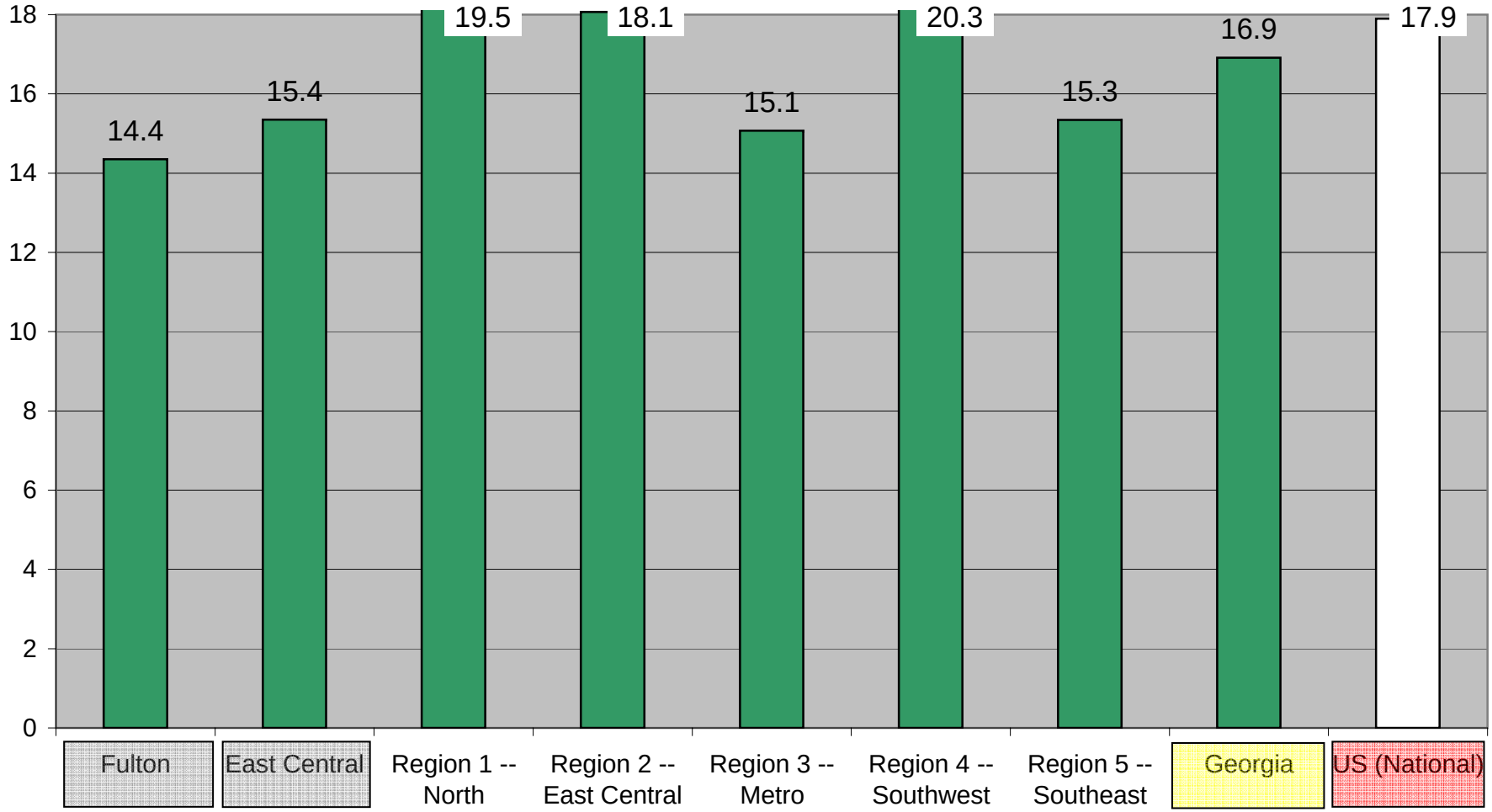


Behavioral Health Link℠

Crisis, Access & Care Management: A Service of Integrated Health Resources

Male Suicide Rates in Georgia 2002 (Per 100,000)

The Georgia Statistics System

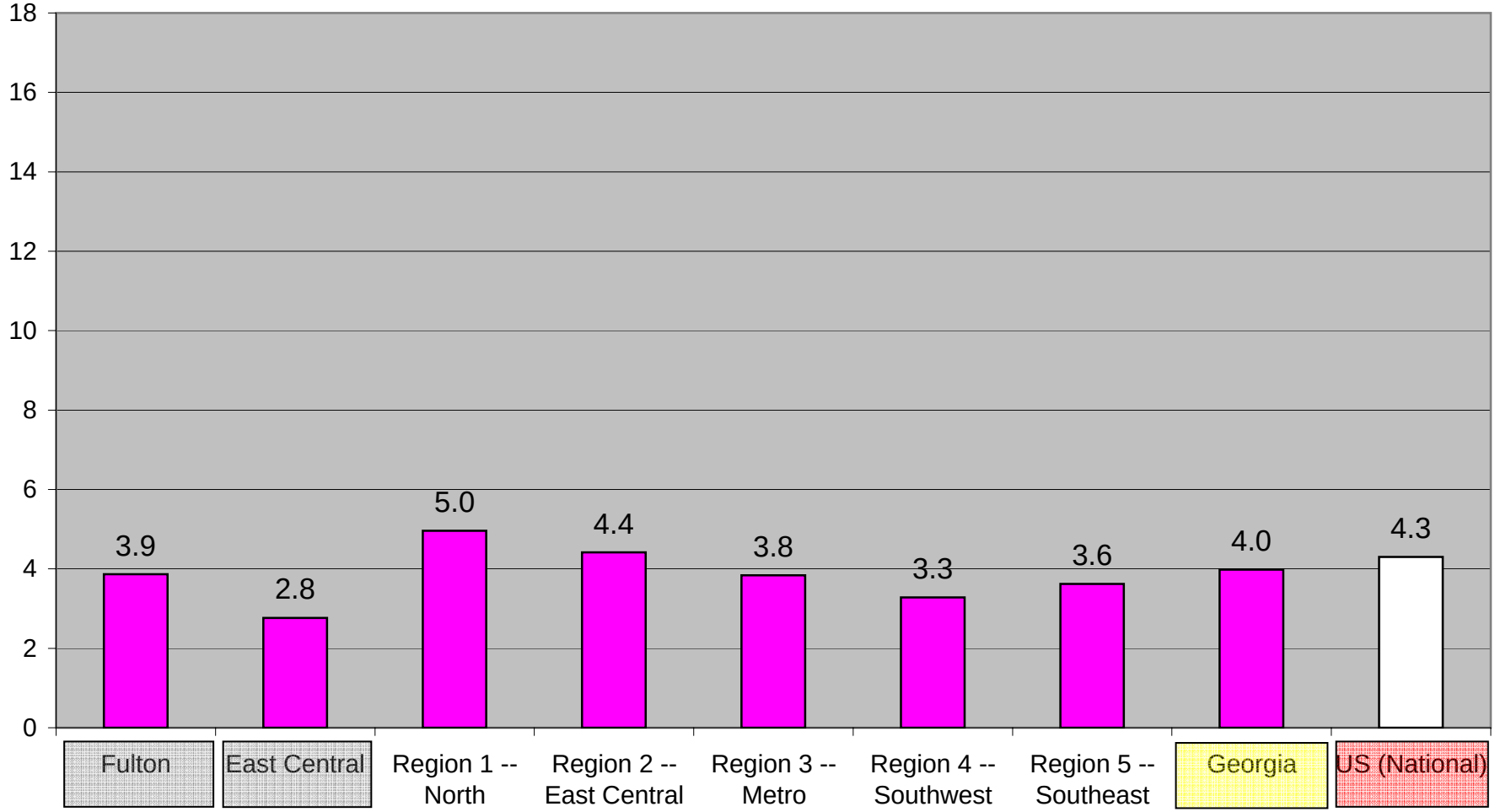


Behavioral Health Link℠

Crisis, Access & Care Management: A Service of Integrated Health Resources

Female Suicide Rates in Georgia 2002 (Per 100,000)

The Georgia Statistics System

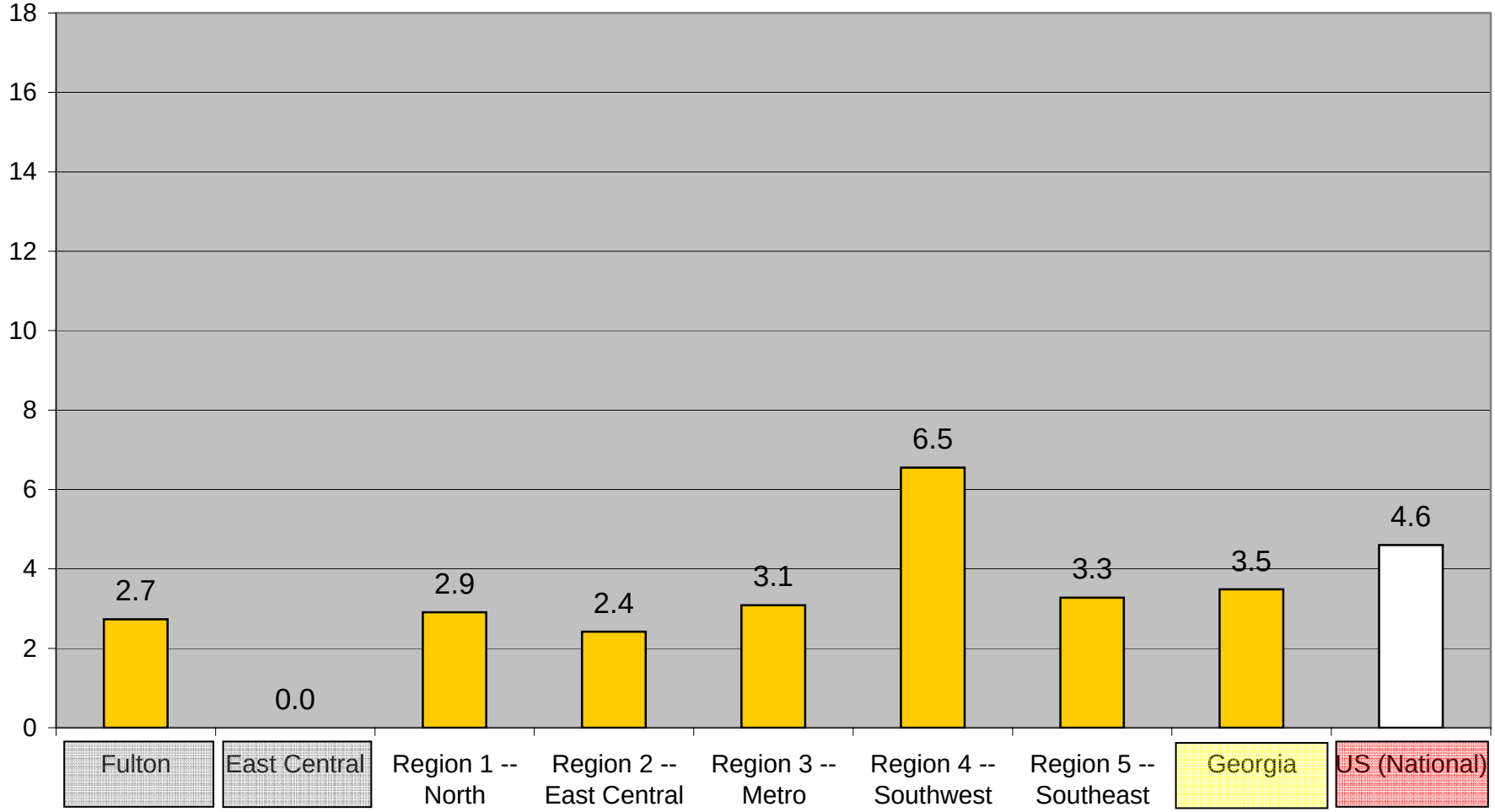


Behavioral Health Link℠

Crisis, Access & Care Management: A Service of Integrated Health Resources

Teen (Ages 10-19) Suicide Rates in Georgia 2002 (Per 100,000)

The Georgia Statistics System

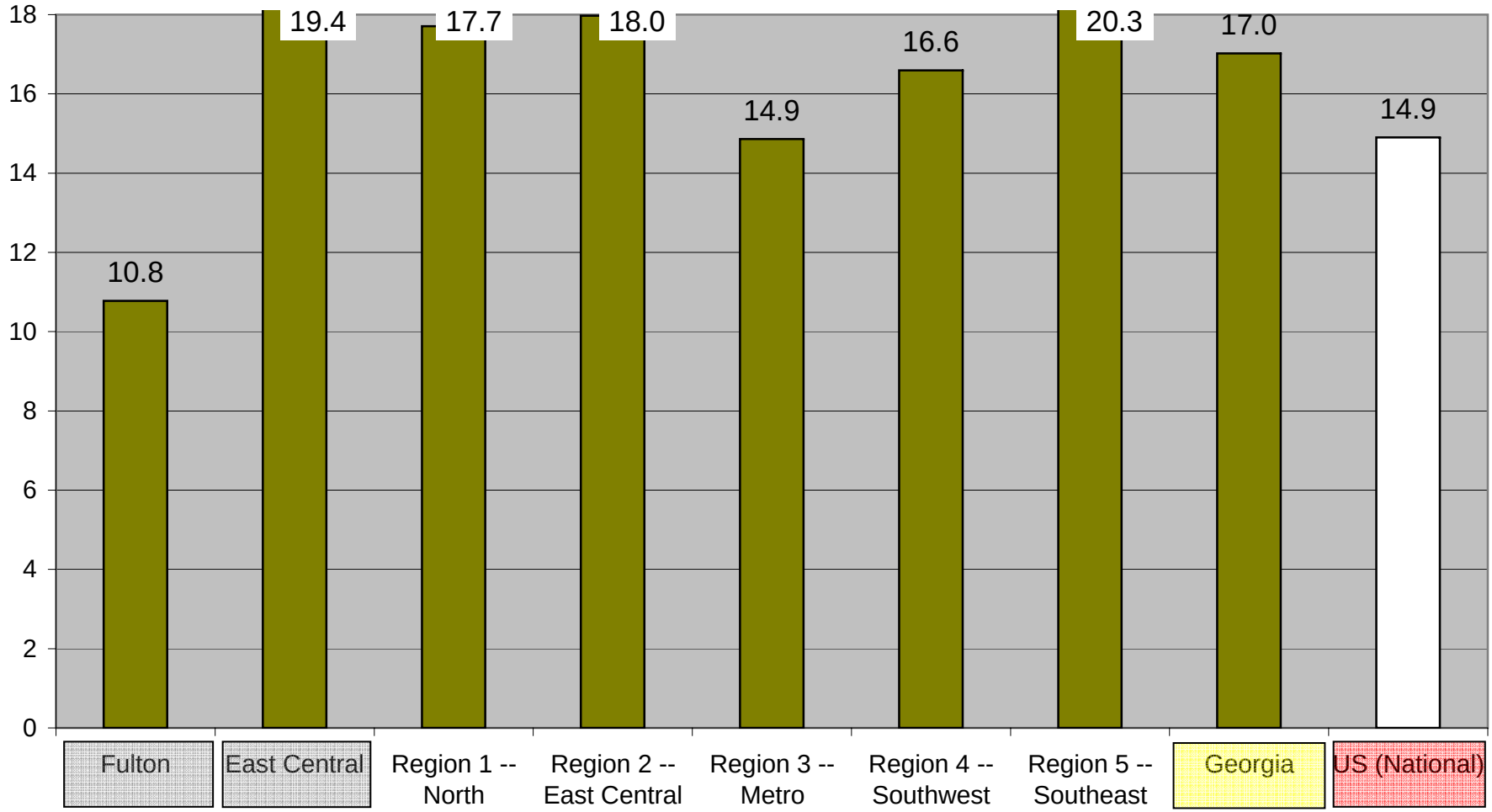


Behavioral Health Link℠

Crisis, Access & Care Management: A Service of Integrated Health Resources

Senior (Ages 60+) Suicide Rates in Georgia 2002 (Per 100,000)

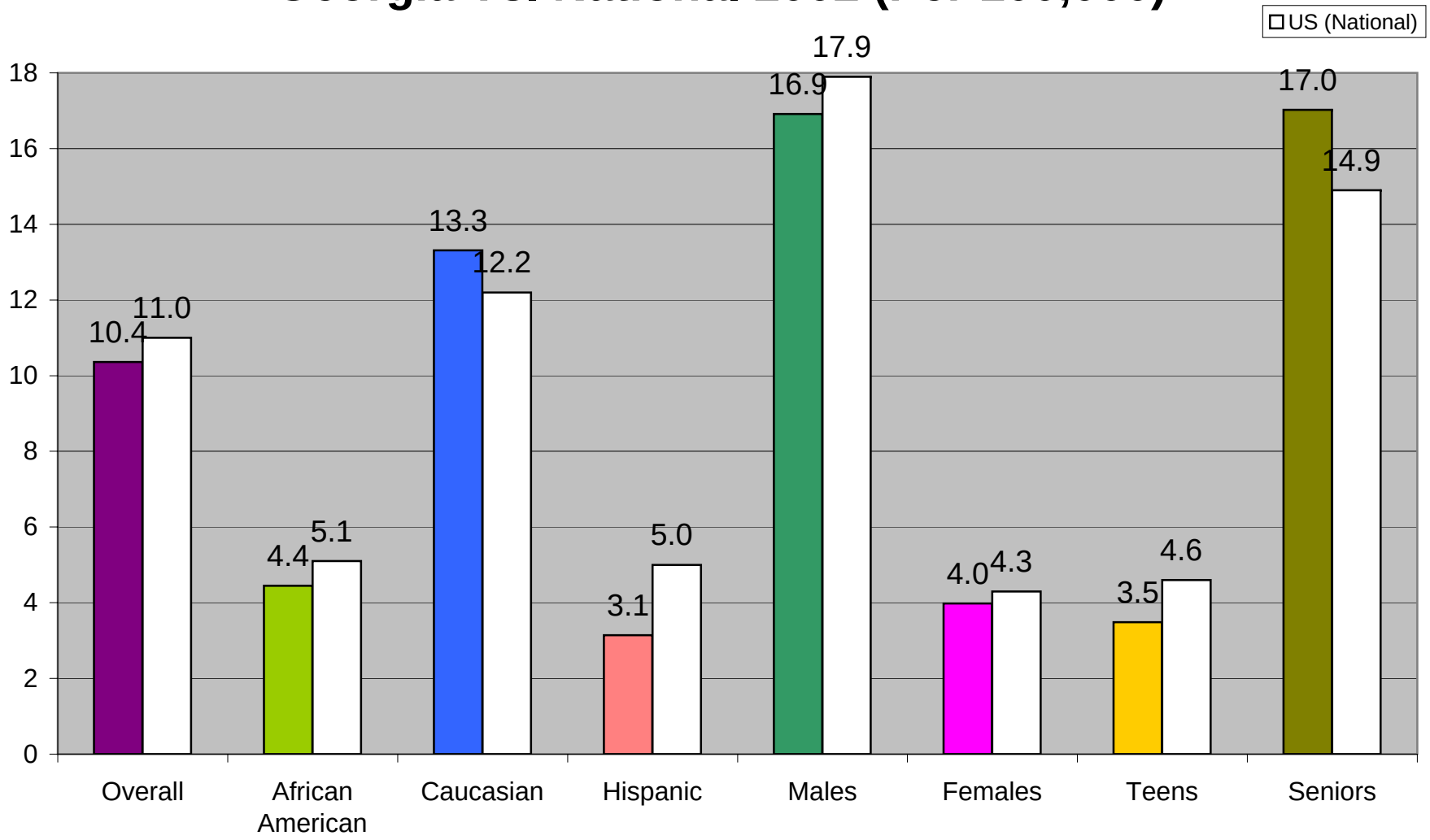
The Georgia Statistics System



Behavioral Health Link℠

Crisis, Access & Care Management: A Service of Integrated Health Resources

Summary & Comparison of Suicide Rates Georgia Vs. National 2002 (Per 100,000)



Behavioral Health Link℠

Crisis, Access & Care Management: A Service of Integrated Health Resources

2003 Population Data (Georgia)

Region	Total Population 2003	White 2003	Black 2003	Hispanic 2003	Males, Total, 2003	Females, Total, 2003	Ages 10-19 Totals	Ages 60+ Totals
Region 1 -- North	**1,193,447**	**1,021,449**	**150,732**	**63,465**	**588,844**	**604,603**	**171,794**	**180,701**
Region 2 -- East Central	**1,427,837**	**1,092,696**	**297,237**	**78,448**	**702,814**	**725,023**	**206,577**	**211,444**
Region 3 -- Metro	**3,669,276**	**2,239,051**	**1,211,535**	**320,971**	**1,818,342**	**1,850,934**	**518,359**	**390,291**
Region 4 -- Southwest	**1,186,598**	**680,657**	**480,667**	**33,471**	**576,986**	**609,612**	**183,272**	**186,799**
Region 5 -- Southeast	**1,207,557**	**824,863**	**356,354**	**44,768**	**599,694**	**607,863**	**183,044**	**182,298**
Georgia Statewide	**8,684,715**	**5,858,716**	**2,496,525**	**541,123**	**4,286,680**	**4,398,035**	**1,263,046**	**1,151,533**
		67.5%	**28.7%**	**6.2%**	**49.4%**	**50.6%**	**14.5%**	**13.3%**

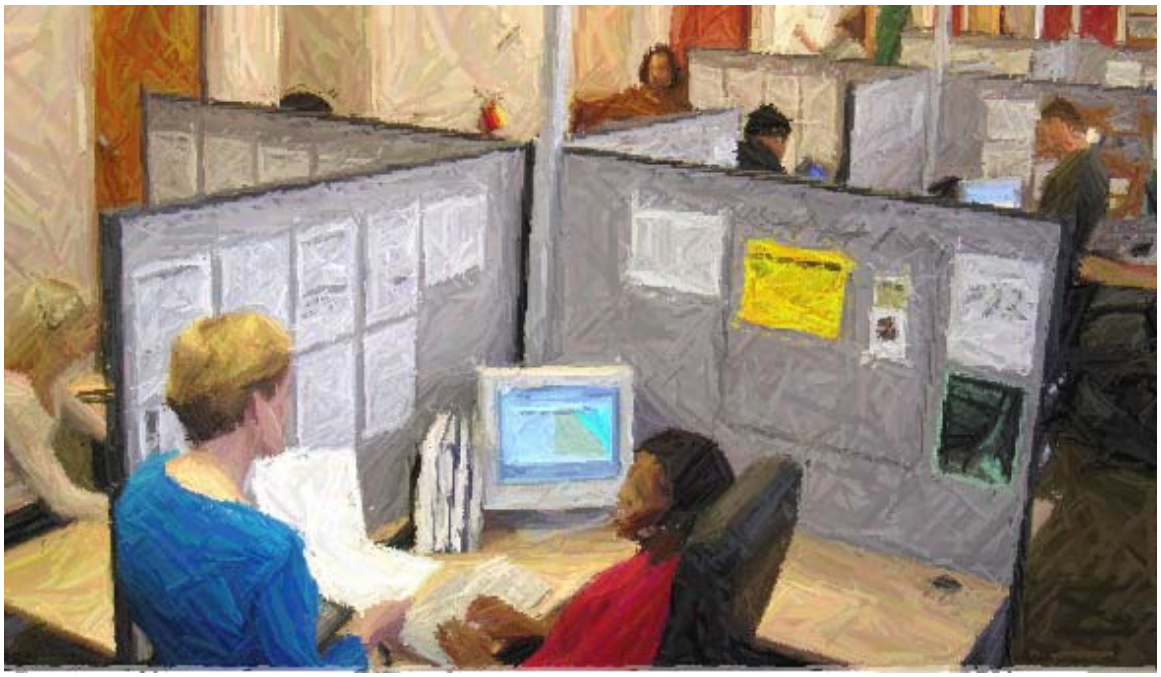
Community Service Board Areas								
Advantage BHS	**378,574**	**297,013**	**71,113**	**15,789**	**185,884**	**192,690**	**53,328**	**52,070**
Albany Area CSB	**185,778**	**92,291**	**90,875**	**2,416**	**88,878**	**96,900**	**29,605**	**29,015**
BHS of South Georgia	**231,004**	**157,689**	**68,956**	**9,818**	**113,554**	**117,450**	**34,986**	**35,047**
Clayton Center CSB	**259,736**	**88,325**	**152,838**	**24,698**	**126,661**	**133,075**	**41,038**	**24,415**
Cobb/Douglas CSB	**753,042**	**560,468**	**155,585**	**64,506**	**374,520**	**378,522**	**105,809**	**81,966**
CSB of Middle Georgia	**138,992**	**92,098**	**45,498**	**2,625**	**69,877**	**69,115**	**20,532**	**24,178**
Dekalb CSB	**674,334**	**264,034**	**374,014**	**59,162**	**328,044**	**346,290**	**87,056**	**77,278**
Fulton County MHMRSA	**818,322**	**426,297**	**352,632**	**55,103**	**404,175**	**414,147**	**109,900**	**92,797**
Gateway CSB	**261,531**	**188,095**	**65,071**	**9,731**	**131,751**	**129,780**	**42,437**	**31,225**
Georgia Mountains CSB	**513,053**	**475,423**	**25,121**	**51,195**	**257,729**	**255,324**	**69,118**	**80,087**
Georgia Pines CSB	**172,369**	**110,627**	**59,505**	**9,813**	**83,820**	**88,549**	**26,249**	**29,724**
GRN CSB	**824,430**	**602,971**	**146,796**	**100,711**	**415,678**	**408,752**	**121,375**	**76,973**
Haralson County	**27,460**	**25,674**	**1,487**	**187**	**13,400**	**14,060**	**3,915**	**4,857**
Highland Rivers BHS	**733,776**	**671,293**	**46,413**	**61,089**	**365,542**	**368,234**	**104,464**	**99,783**
Lookout Mountain CSB	**163,001**	**154,580**	**5,844**	**2,215**	**80,139**	**82,862**	**22,493**	**28,716**
McIntosh Trail CSB	**390,690**	**294,425**	**84,657**	**9,735**	**192,344**	**198,346**	**61,173**	**52,782**
Middle Flint BHC	**117,364**	**61,393**	**54,671**	**3,045**	**56,497**	**60,867**	**18,158**	**19,195**
New Horizons CSB	**255,792**	**139,792**	**106,943**	**8,894**	**128,017**	**127,775**	**40,446**	**38,450**
Oconee Center CSB	**118,099**	**65,240**	**51,556**	**1,915**	**59,475**	**58,624**	**17,022**	**19,715**
Ogeechee BHS	**88,643**	**49,021**	**38,877**	**2,206**	**42,400**	**46,243**	**14,593**	**14,886**
Pathways Center	**294,076**	**226,249**	**62,773**	**9,079**	**143,907**	**150,169**	**44,283**	**41,026**
Phoenix Center BHS	**157,307**	**108,884**	**43,510**	**4,915**	**77,244**	**80,063**	**25,361**	**21,299**
Pineland Area CSB	**186,796**	**137,924**	**46,543**	**10,727**	**93,942**	**92,854**	**27,947**	**28,057**
River Edge BHC	**213,469**	**117,060**	**92,406**	**2,704**	**99,698**	**113,771**	**31,776**	**34,603**
SABHC	**235,270**	**131,699**	**95,498**	**4,700**	**113,254**	**122,016**	**33,620**	**39,290**
Satilla CSB	**141,803**	**109,205**	**30,853**	**6,371**	**70,875**	**70,928**	**21,171**	**22,483**
Serenity BHS	**350,004**	**210,946**	**126,490**	**7,774**	**169,375**	**180,629**	**55,191**	**51,616**
Georgia Statewide	**8,684,715**	**5,858,716**	**2,496,525**	**541,123**	**4,286,680**	**4,398,035**	**1,263,046**	**1,151,533**
		67.5%	**28.7%**	**6.2%**	**49.4%**	**50.6%**	**14.5%**	**13.3%**

2002 Suicide Statistics (Georgia)

Region	Suicides, Total	Homicides, Total	Suicides, White	Suicides, Black, 2002	Suicides, Hispanic, 2002	Suicides, Males	Suicides, Females	Suicides, Teen 10 - 19	Suicides, Ages 60+
Region 1 -- North	145	60	141	4	1	115	30	5	32
Region 2 -- East Central	159	75	150	9	1	127	32	5	38
Region 3 -- Metro	345	333	275	62	12	274	71	16	58
Region 4 -- Southwest	138	87	116	22	2	117	20	12	31
Region 5 -- Southeast	113	116	98	14	1	92	22	6	37
Georgia Statewide	900	671	780	111	17	725	175	44	196
		74.6%	86.7%	12.3%	1.9%	80.6%	19.4%	4.9%	21.8%
Community Service Board Areas									
Advantage BHS	38	27	36	2	0	33	5	1	9
Albany Area CSB	21	13	17	4	0	16	5	1	5
BHS of South Georgia	26	21	24	2	0	20	6	1	8
Clayton Center CSB	32	23	23	9	1	26	6	1	5
Cobb/Douglas CSB	74	37	70	3	2	60	14	3	16
CSB of Middle Georgia	14	9	12	2	0	12	2	0	9
Dekalb CSB	65	83	41	22	5	51	14	6	12
Fulton County MHMRSA	74	149	49	24	0	58	16	3	10
Gateway CSB	24	24	18	6	0	21	4	3	4
Georgia Mountains CSB	65	21	63	2	1	50	15	3	13
Georgia Pines CSB	23	11	19	4	2	22	1	2	5
GRN CSB	79	33	72	4	4	59	20	2	11
Haralson County	11	1	11	0	0	8	3	0	1
Highland Rivers BHS	82	32	81	1	1	62	20	5	16
Lookout Mountain CSB	17	6	17	0	0	15	2	1	5
McIntosh Trail CSB	37	15	34	2	0	31	6	0	7
Middle Flint BHC	10	10	4	6	0	8	1	2	1
New Horizons CSB	32	27	27	5	0	25	7	4	8
Oconee Center CSB	18	6	15	3	0	15	3	2	7
Ogeechee BHS	8	7	7	1	1	7	1	0	2
Pathways Center	32	16	30	2	0	27	5	0	8
Phoenix Center BHS	18	3	17	1	0	15	3	1	2
Pineland Area CSB	17	10	15	1	0	14	3	0	6
River Edge BHC	20	19	20	0	0	18	2	1	5
SABHC	16	44	14	2	0	14	2	1	6
Satilla CSB	16	7	15	1	0	12	4	1	5
Serenity BHS	31	17	29	2	0	26	5	0	10
Georgia Statewide	900	671	780	111	17	725	175	44	196
		74.6%	86.7%	12.3%	1.9%	80.6%	19.4%	4.9%	21.8%

Suicide Rates Per 100,000 (Georgia)

Region	Suicides, Total	Homicides, Total	Suicides, White	Suicides, Black, 2002	Suicides, Hispanic, 2002	Suicides, Males	Suicides, Females	Suicides, Teen 10 - 19	Suicides, Ages 60+
Region 1 -- North	12.1	5.0	13.8	2.7	1.6	19.5	5.0	2.9	17.7
Region 2 -- East Central	11.1	5.3	13.7	3.0	1.3	18.1	4.4	2.4	18.0
Region 3 -- Metro	9.4	9.1	12.3	5.1	3.7	15.1	3.8	3.1	14.9
Region 4 -- Southwest	11.6	7.3	17.0	4.6	6.0	20.3	3.3	6.5	16.6
Region 5 -- Southeast	9.4	9.6	11.9	3.9	2.2	15.3	3.6	3.3	20.3
Georgia Statewide	10.4	7.7	13.3	4.4	3.1	16.9	4.0	3.5	17.0
Community Service Board Areas									
Advantage BHS	10.0	7.1	12.1	2.8	0.0	17.8	2.6	1.9	17.3
Albany Area CSB	11.3	7.0	18.4	4.4	0.0	18.0	5.2	3.4	17.2
BHS of South Georgia	11.3	9.1	15.2	2.9	0.0	17.6	5.1	2.9	22.8
Clayton Center CSB	12.3	8.9	26.0	5.9	4.0	20.5	4.5	2.4	20.5
Cobb/Douglas CSB	9.8	4.9	12.5	1.9	3.1	16.0	3.7	2.8	19.5
CSB of Middle Georgia	10.1	6.5	13.0	4.4	0.0	17.2	2.9	0.0	37.2
Dekalb CSB	9.6	12.3	15.5	5.9	8.5	15.5	4.0	6.9	15.5
Fulton County MHMRSA	9.0	18.2	11.5	6.8	0.0	14.4	3.9	2.7	10.8
Gateway CSB	9.2	9.2	9.6	9.2	0.0	15.9	3.1	7.1	12.8
Georgia Mountains CSB	12.7	4.1	13.3	8.0	2.0	19.4	5.9	4.3	16.2
Georgia Pines CSB	13.3	6.4	17.2	6.7	20.4	26.2	1.1	7.6	16.8
GRN CSB	9.6	4.0	11.9	2.7	4.0	14.2	4.9	1.6	14.3
Haralson County	40.1	3.6	42.8	0.0	0.0	59.7	21.3	0.0	20.6
Highland Rivers BHS	11.2	4.4	12.1	2.2	1.6	17.0	5.4	4.8	16.0
Lookout Mountain CSB	10.4	3.7	11.0	0.0	0.0	18.7	2.4	4.4	17.4
McIntosh Trail CSB	9.5	3.8	11.5	2.4	0.0	16.1	3.0	0.0	13.3
Middle Flint BHC	8.5	8.5	6.5	11.0	0.0	14.2	1.6	11.0	5.2
New Horizons CSB	12.5	10.6	19.3	4.7	0.0	19.5	5.5	9.9	20.8
Oconee Center CSB	15.2	5.1	23.0	5.8	0.0	25.2	5.1	11.7	35.5
Ogeechee BHS	9.0	7.9	14.3	2.6	45.3	16.5	2.2	0.0	13.4
Pathways Center	10.9	5.4	13.3	3.2	0.0	18.8	3.3	0.0	19.5
Phoenix Center BHS	11.4	1.9	15.6	2.3	0.0	19.4	3.7	3.9	9.4
Pineland Area CSB	9.1	5.4	10.9	2.1	0.0	14.9	3.2	0.0	21.4
River Edge BHC	9.4	8.9	17.1	0.0	0.0	18.1	1.8	3.1	14.4
SABHC	6.8	18.7	10.6	2.1	0.0	12.4	1.6	3.0	15.3
Satilla CSB	11.3	4.9	13.7	3.2	0.0	16.9	5.6	4.7	22.2
Serenity BHS	8.9	4.9	13.7	1.6	0.0	15.4	2.8	0.0	19.4
Georgia Statewide	10.4	7.7	13.3	4.4	3.1	16.9	4.0	3.5	17.0



Section IV

Crisis Call Center Evaluation Studies

Remarks by A. Kathryn Power, M.Ed.
Director

Center for Mental Health Services
Substance Abuse and Mental Health Services Administration
U.S. Department of Health and Human Services

Presentation of Results: Suicide Prevention Hotline Evaluation and Linkage Report

Rockville, MD, March 24, 2005

Good morning. Welcome to our overview of the Suicide Prevention Hotline Evaluation and Linkage Project. You soon will hear the results from two project evaluation studies. The first, presented by Dr. Brian Mishara, is a monitoring study of calls received by the Hopeline Network. This study evaluates the nature of helper assistance provided to callers in crisis, with the long-term goal of improving standards of service delivery. The second study, presented by Drs. Madelyn Gould and John Kalafat, examines short-term outcomes for suicidal callers and others in crisis. These evaluations are among the most important studies of crisis services ever conducted. Why?—Because they respond directly to questions about the effectiveness of crisis hotlines and the role crisis centers play in the support systems we fund.

Let me extend my personal greetings to two groups who are here. First, I sincerely thank the crisis center directors whose participation made these evaluation studies possible. With your support, evaluators were able to deal effectively with challenges presented by the studies, such as privacy issues. In addition, you willingly opened up your centers to close scrutiny—and risked possible criticism—in the interest of others. Your deep commitment to providing better services to people contemplating suicide or facing similar personal crises truly is admirable.

Your cooperation demonstrates a point I frequently make when I talk about the future of mental health care. Our overarching goal is to transform the mental health system into one that is consumer driven and focused on recovery, and that will build a person's resilience to face life's challenges. Achieving this goal may demand personal as well as system change. It will be *our* readiness to change and *our* willingness to risk that will determine the speed and scope of the progress we make.

Second, I offer a heartfelt welcome to the members of the steering committee for the National Suicide Prevention Lifeline. Your role as committee members is twofold: (1) to help the Mental Health Association of New York City administer the Lifeline, and (2) to help the Substance Abuse and Mental Health Services Administration/Center for Mental Health Services move forward with effective, life-affirming crisis and suicide prevention services. Today, you will develop a deeper understanding of the issues involved and possible options for resolving them. Use this knowledge as your foundation to help us shape policies, establish standards, and design project evaluations that will guide the Lifeline's development. I am looking to you to help ensure that the National Suicide Prevention Lifeline fulfills the promise of its name.

These two evaluation studies can teach us a great deal about necessary as well as potential improvements to crisis center services. View the results of these studies in the broad context of what we hope to achieve through their analysis. Our goal is to improve national standards and methods of service delivery, including linkages between crisis centers and community-based services that can provide follow-up care to callers.

We have a shared responsibility to use all the results as guidelines for prioritizing improvements. We have invited center directors here today to emphasize how strongly we want to work *with you* on making necessary changes. We will begin *today* by giving everyone an opportunity for input at the conclusion of the presentations.

There should be a sense of urgency behind our efforts. In 2002, the last year for which data are available, more than thirty-one thousand individuals committed suicide. *Thirty-one thousand* lives lost. Also lost: all the wonderful contributions these individuals could have made to their families, their professions, and their communities. In the United States, suicide has become a public health crisis that affects us all.

It's interesting to note that the Chinese word for "crisis" is written with two characters. The first character is for "danger"; the second is for "opportunity". These characters symbolize the pivotal point that we have reached in establishing crisis centers and their services within their community mental health systems.

Consider the course of action we can take in light of the evaluation results. The thousands of individuals who call crisis hotlines each year do so because they are at serious risk of harming themselves or others. The sheer number of callers, and particularly the number of *repeat* callers, reveals a critical gap in our mental health system. That gap is the capacity to identify individuals at risk and to intervene early enough with appropriate supports that will prevent crises. Too many individuals still wait until they have lost nearly all hope in themselves, their lives, and their futures *before* they are willing to seek help.

The tragedy in Red Lake is a stark reminder to all of us of why we are here today. We must redouble our efforts to ensure that young people like Jeff Weise know that there *is* a place where they can be heard and—most important—*helped* to face the many challenges of their young lives.

We must do everything within our power to reduce the danger of suicide to individuals and our communities. How?—By improving immediately the safety networks of services that respond to the short- and long-term mental health needs of people in crisis. The conclusions presented by our own evaluation studies demonstrate that we have numerous *opportunities* to transform crisis service centers.

The studies, for example, suggest that we can improve services by looking closely at certification standards and at methods to ensure that crisis centers adhere to them. We also can use the crisis hotline evaluation study as an opportunity to understand better how crisis centers and other service systems are working together. This knowledge can help us develop better system linkages.

Crisis centers play a vital role in preventing suicide and in linking callers to appropriate followup care. In fact, these centers represent the community-based coalitions of care that should *define* the future of national mental health care, with all citizens—from mental health professionals to volunteers—working together for the common good.

Why the emphasis on community? —Because a suicide never affects just one individual or even just one community. Suicide is a disease that can spread. Among the risk factors listed by the National Institute of Mental Health is this one: exposure to the suicidal behavior *of others*, including family members, peers, or even through the media.

We must take action to engage our communities in efforts to provide early identification and support to those in crisis. To paraphrase Martin Luther King, Jr., " *At the heart of all that civilization has meant and developed is ' community:' the mutually cooperative and voluntary venture of [people] to assume a semblance of responsibility for [others]."* It falls on us to strengthen crisis centers so they can best meet this responsibility.

And, now, I'd like to introduce Dr. Brian Mishara. Dr. Mishara is the director of the Centre for Research and Intervention on Suicide and Euthanasia at the University of Quebec in Montreal. He is a founder of Suicide Action Montreal and vice president of the International Association for Suicide Prevention. Dr. Mishara, as project director, will be presenting the results and recommendations from "A Silent Monitoring Study of Telephone Help Provided Over the Hopeline Network and Its Short-Term Effects."

"A Silent Monitoring Study of Telephone Help Provided Over the Hopeline Network and its Short-term Effects"

by Brian Mishara, University of Quebec at Montreal, et al

Summary *by Reese Butler, National Hopeline Network*

The long-awaited Silent Monitoring Study of the National Hopeline Network (NHN) has been released. It is loaded with information and is well worth the wait and the time it takes to glean all of the useful data, which includes 205 pages and an executive summary.

The study is packed with powerful conclusions and recommendations. It confirms that when proper risk assessments and good initial connections are made, positive outcomes can be expected...

The evaluators found that in 85 percent of all the calls that were monitored, good contact was made and the caller was satisfied with what occurred on the call. The need to improve that percentage is evident by the failures of the call takers in at least 15 percent of the calls. In those calls, the call takers did not make good contact, conduct risk assessments, and send rescue when the caller appeared to need it.

In their overall findings, researchers found that callers benefit from the help they receive over the Hopeline Network. They also found that when change occurs from the beginning to the end of a call, it is generally positive. In some instances, lives may have been saved by timely rescues in which ambulances were sent and in skilled interventions where a person intending to commit suicide was convinced to abort an attempt and obtain help.

CRIES is the application that the study's leader, Brian Mishara and his team used to conduct the silent monitoring study. The application was paid for by a federal grant from the Substance Abuse and Mental Health Services Administration and is available for all crisis centers in the Hopeline Network to use for free...

Study Outline

The study is broken into eight chapters: Goals and Approach to the Study; What We Have Learned From Previous Studies; Developing the Models and Measures and Silent Monitoring; Methodology for the Silent Monitoring; Characteristics of Callers and Calls Monitored; Process of Telephone Intervention: What Helpers Do; Call Outcomes, Differences between Centers; and Conclusions and Recommendations.

Its overall finding: the need for better quality control-monitoring. This means having the capabilities to see what crisis centers really do at 2 a.m. when no supervisors are available. In additions, crisis centers should be able to document that each call was handled according to the agencies' proven best practices, a list of effective procedures. Quality

control also includes matters, such as making sure callers are not yelled at, told to take a bath or given other inappropriate advice. Researchers found some instances of this inappropriate advice in the study.

The results of the study called for better helper-call taker selection-using criteria that include empathy, respect, and ability to establish good initial contact. This was demonstrated by the inconsistency from worker to worker and center to center.

The study also identified that there is a need for improved training and use of Suicide Risk Assessment (SRA), a series of questions that are asked of suicidal persons to determine their likelihood of committing suicide. Adequate supervision also is needed to ensure that the risk assessments are conducted and appropriate next steps are taken.

The study focused on three short-term goals: describing the current nature of help provided on the NHN; assess short-term effects of the telephone help; and determine the relationship between the different intervention practices and the outcome of the calls.

Ironically, the study also found that many crisis center directors' descriptions of what their centers do are not necessarily accurate. This, researchers say, does not imply that call takers are not doing a good job. Instead it shows a need for future studies that analyze the content of training sessions for call takers at different centers in order to determine what helpers are actually taught to do.

Researchers compared two distinct styles: directive and non-directive. The styles are much as the names imply. The directive approach, which tries to get the callers to take action to improve their lives, is related to good outcomes. In the non-directive approach, crisis line worker plays an active role in the exploration process and the search for solutions.

Summary and Conclusions:

Overall, the study found that callers benefit from the help they receive over the NHN and that lives may have been saved as a result of the work done over the network. Fourteen agencies and 782 crisis line workers agreed to participate in the study and 1,431 calls were the final sample use in analyses. Half of the centers used the directive approach, while the other 50 percent used the non-directive approach. The study used the Virtual Private Network (VPN) to protect the callers' confidentiality through access and use of the system. The CRIES was used to conduct silent unobtrusive monitoring. Real-time call trace was also used to be able to send rescue personnel when callers were incapacitated.

Of the calls received:

- 52 % involved crisis where suicide was not discussed
- 36 % were calls from suicidal people
- 12 % were from third parties concerned about a loved ones ideation of suicide

Quality varies greatly:

- 223 calls (15.6%) included at least one negative helper behavior
- Lack of empathy (6.1%)
- Lack of respect (2.2%)
- Poor Initial contact (5.1%)
- Telling caller to commit suicide (.02%) 4 cases
- Not offering any help (6.1%)
- Aggressive or rude (5.3%)
- End call to take another call (3.2%)
- Referring elsewhere without discussing the problem (2.6%)

Nature of calls:

- Suicide in progress 33 callers -- (2.3%)
- Had plan and intent 182 -- (12.7%)
- Expressed intent 288 -- (20.1%)
- Suicidal crisis 503 -- (35.1%)
- Third-party calls about suicide crisis 178 -- (12.4%)
- 13 had just slashed wrists
- 11 had taken an overdose
- 1 had a firearm attached to a string

Establishing Contact at the beginning of the call:

- 81% established good contact at the beginning of the call
- 5% said there was not good contact
- 17% unable to say if good contact was made

Questions asked of callers:

- Only 31 of the 472 callers who were suicidal were asked if they could control their thoughts
- 64 were asked where they were
- 182 were asked if they were alone
- 5 were asked if they had taken any substances

Out of the 33 suicides in progress:

- 6 were sent rescue services and only 3 remained on the line
- 10 were not offered any rescue services
- 9 offers of help were refused
- 8 ended with the caller changing their mind, with 1 agreeing to accept a follow-up call

CONCLUSIONS:

- People in need, those in crisis and suicidal crises, call the Hopeline Network
- Callers appear to be helped in significant numbers of calls
- Center directors' descriptions of what helpers do is not necessarily accurate (we found no significant relationship between center directors' descriptions of what their helpers do and what we observed)
- Empathy and Respect are Desired Helper Qualities; they relate to better call outcomes
- Helper behaviors in the category Supportive Attitude and Good Contact are related to better outcomes
- Directive Style is also related to positive outcomes
- Helpers do not consistently evaluate suicide risk, and when evaluations are conducted they are usually incomplete
- Things « not to do » have little effect, except sharing personal experience is related to better outcomes
- Some lives may have been saved
- Some "unacceptable" behaviors occur, and this may result in negative consequences for callers
- Centers vary greatly in the nature (and quality) of the telephone help they provide and the extent to which the calls they answer have positive outcomes

RECOMMENDATIONS

- There is a need for continued quality control monitoring to ensure that calls are handled in the way centers desire and to improve the quality of help provided
- Helper selection criteria should include: empathy, respect and the ability to establish a good initial contact
- Training curriculum should include practice in intervention methods that are related to positive outcomes, including the importance of establishing a good initial contact, showing respect for callers, validation of callers' feelings and the more directive problem solving approach
- Risk assessment needs to be improved by better training and supervision, not just whether or not an assessment is made, but also to ensure that when a caller expresses suicidal ideation, a complete assessment is conducted
- There is a need to conduct further research using unobtrusive, silent, monitoring procedures and relate the process of interventions, not only to the short term effects observed during the calls, but also to long term outcomes after the call has ended.

Hotline Evaluation and Linkage Project Category II

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SAMHSA Collaborative Agreement U79SM54128

Summary Prepared for the National Suicide Prevention Lifeline Network
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GOALS

The goals of this project were to:

1. Evaluate the *immediate outcomes* of calls to Telephone Crisis Services (TCS) by callers who are either suicidal or were experiencing other nonsuicidal crises.

   This involved an assessment of the impact of interventions with a caller during a given call. This is the *baseline* sample.
   In order to measure these changes, we employed 1) For nonsuicide crisis calls: a brief version of a validated instrument called the Profile of Mood States (POMS), which consists of a list of 12 words that capture the emotional and cognitive aspects of the crisis state; and, additional questions assessing helplessness, feeling overwhelmed, and hopelessness; 2) For suicide calls: a brief standard suicide risk assessment that is based on the most current research on factors that capture critical aspects of the suicidal state. Staff at participating centers were trained to obtain this data near the beginning (Time 1) and at the end (Time 2) of eligible calls.

2. Evaluate the *intermediate outcomes* for suicidal and nonsuicidal crisis calls.

   In addition to changes *during* the call, we assessed how callers were faring *after* the call. Follow up calls were made within 2-3 weeks on average of the call and re-assessed crisis and suicide status. Caller feedback on and satisfaction with the call, as well as whether the caller followed up on specific plans developed or referrals recommended in the call were also assessed. Independent evaluators who had crisis intervention training made the follow up calls.

3. Evaluate the *community context* of TCS.
   That is, to what extent are TCS familiar to and accepted by relevant agencies in their communities? This data was obtained through surveys of about 15 local community agencies provided by four participating TCS. The community context was also assessed by a survey of a group of people who were more likely to, or should know about the local TCS. Local psychiatric emergency services identified by two TCS included 4 questions on their intake assessment concerning familiarity with, use of, and satisfaction with the TCS by clients presenting to their agency.

SAMPLE

The following tables present the characteristics of the participating centers, the caller sample at baseline, and at follow up. Not all calls were eligible for baseline assessments, including I & R calls; callers who could not be assessed due to their current mental state, intoxication, or belligerence; third party calls (not in crisis), frequent/chronic callers, non-English speaking callers, and minors. In addition, some eligible callers were not assessed due to high call volume (32%), phone problems (6.1%), caller refused/hung up (26.3%), high risk suicide (26.5%), and counselor did not think assessment was appropriate for this call (9.2%).

Crisis Center Characteristics

(N=8)

- 6 States: Midwest (2); Northeast (4); South (1); West (1)
- Counselors: Paid Staff (4); Volunteers (3); Mixed (1)
  88 from Paid Staff; 136 from Volunteer Staff
- Annual Call Volume: 7,993 – 85,000
- Data Collection Period: 3/03 – 7/04

Baseline Sample

	CRISIS N=1617	SUICIDE N=1085	TOTAL N=2702†
Male	25.9% (418)	39.1% (424)***	31.2%
Female	73.9% (1195)	60.1% (652)	68.4%

†52.3% of all eligible callers
(Range per center = 20.9% - 74.4%)

***p<.001

Follow-Up Sample

	CRISIS (N = 801/1617)	SUICIDE (N = 380/1085)
Follow-Up Rate	49.5%	35.0%*
Male	23.6%	30.3%*
Female	76.4%	69.7%
Mean Age	37.6 yrs	36.1 yrs*
Age Range	18-85 yrs	18-72 yrs

*p<.05

RESULTS

Crisis Calls

For the 1617 crisis calls on which baseline assessments were completed, there were significant reductions in callers' confusion, depression, anger, anxiety, helplessness, overwhelmed, and hopelessness from the beginning of the call (time 1) to the end of the call (time 2), indicating a significant immediate positive impact of the calls.

At follow up, there were further significant reductions in those same variables from the end of the call (time 2) to the follow up call (time 3). The extent to which the crisis callers were given referrals and followed through with them is presented below. The majority of these callers were given a new referral (67.5%), of which 20.2% had completed at least one appointment within 2-3 weeks of the initial call. Another 12.2% had set up an appointment. Note that of the 541 callers who received new referrals, 392, nearly half of the callers in the follow up sample, received mental health referrals. Of these, 33.2% had followed up with the referral at the time of the follow up call by either completing an appointment or setting up an appointment.

Crisis Callers at Follow Up: Rate of Referrals

New referral:

Any = 67.5% (541/801)

Mental health = 48.9% (392/801)

Referral back to:

Crisis center = 10.4% (83/801)

Current therapist/ongoing services = 13.5% (108/801)

Total Referrals = 78.4% (628/801)

Crisis Callers at Follow Up: Follow Through with *New* Referrals

- Completed Any Appt = 20.2% (110/541)
- Completed MH Appt* = 17.6% (69/392)

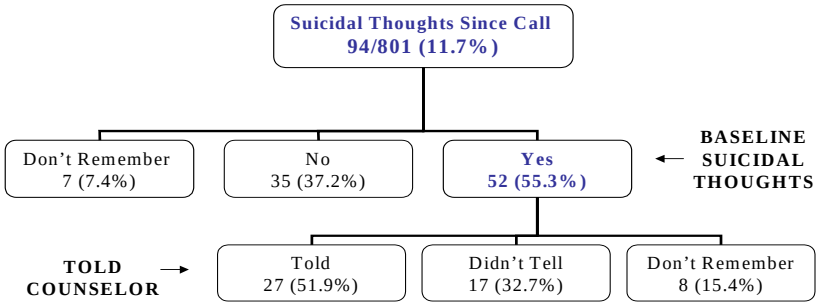
- Set up Any Appt = 12.2% (66/541)
- Set up MH Appt* = 15.6% (61/392)

➢ 13.7% of all crisis callers (110/801) are completing at least one appointment with *new* service within 1 month of call

* Mutually exclusive categories

The following table indicates that 11.7% of the crisis callers had suicidal thoughts since their call and that more than half of them were feeling suicidal at baseline (6.5% of the 801 follow-up callers). Seventeen of them did not tell the counselor. Compared to the 706 who did not endorse suicide at follow up, these 94 were significantly more distressed and hopeless at baseline. We don't know how many of the baseline crisis callers who did not consent to a follow up might have been feeling suicidal. This indicates that it may be useful to inquire about suicidal feelings of all crisis callers.

Crisis Callers → Suicidal at Follow Up (I)



Suicide Calls

The following table depicts the baseline sample of suicide callers. Over half of the suicide callers had a plan when they called the center and 8% had taken some action to harm or kill him/herself immediately before the call. Also, 57.5% had made some prior attempt. These data do not include the higher risk callers, who were not assessed at baseline. However, they clearly represent an at-risk population, indicating that TCS are receiving calls from at risk callers.

Suicide Callers: Risk Profile at Baseline

(N=1085)

	N	%
Plans (current)	585	53.9%
Action (current)	88	8.1%
Attempts (ever):	624	57.5%
Single	275	44.1% of attempts
Multiple	332	53.2% of attempts
(Missing information	17	2.7% of attempts)

Of the 1085 suicidal callers assessed at baseline, 380 consented to a follow up call. For these callers, there were significant reductions in suicide status from the beginning of calls to the end of the calls (time 1 to time 2) and at follow up (time 2 to time 3), as measured by intent to die, psychological pain, and hopelessness. Of these 380 callers, 43.2% had suicidal thoughts, 7.4% had made plans, and 2.9% had made attempts since their call to the TCS.

The following tables present the extent to which the suicide callers were given referrals and followed through with them. The majority of these callers were given a new referral (58.2%), of which 28.5% had completed at least one appointment within 2-3 weeks of the initial call. Another 8.6% had set up an

appointment. 35.1% of those who had been given a mental health referral had followed up with that referral by either completing an appointment or setting up an appointment.

Suicide Callers at Follow Up: Rate of Referrals

New referral:

Any = 58.2% (221/380)

Mental health referral = 39.7% (151/380)

Referral back to:

Crisis center = 29.2% (111/380)

Current therapist/ongoing services = 19.2% (73/380)

Total Referrals = 77.9% (296/380)

Suicide Callers at Follow Up: Follow Through with New Referrals

- Any Completed Appt = 28.5% (63/221)
- MH Completed Appt* = 22.5% (34/151)

- Any Set up Appt = 8.6% (19/221)
- MH Set up Appt* = 12.6% (19/151)

➢ 16.6% of all suicide callers (63/380) are completing at least one appointment with *new* service within 1 month of call

*Mutually exclusive categories

Caller Feedback

During the follow up call, callers were asked to provide feedback on their call to the crisis centers. The first two questions in this segment of the follow up interview consisted of open-ended questions:

1. Thinking back to the call you placed to the crisis line, can you tell me how the call was helpful to you? (total of 2017 responses provided)
2. Can you tell me what was not helpful about the call? (total of 212 responses provided).

Their responses were reliably coded into categories by two raters and the following table depicts their most common responses to the first question. Many categories accounted for a small percent of the responses. However, the top six categories of responses to open-ended questions for both suicide and crisis calls support the logic of telephone crisis services. The most frequent comments describe empathic helpers who listened and allowed the callers to talk about their concerns, helped them to calm down and think more clearly, and provided options for dealing with their concerns. The services were described as readily available and the helpers willing to stay on the line as long as needed (i.e., patient). In addition 14% of suicide callers said that the call prevented them from harming or killing themselves.

Caller Qualitative Feedback

	% of Suicide Callers Who Made Response	% of Crisis Callers Who Made Response
Listen & let talk	38.68	39.20
Think more clearly/ New perspective	12.89	11.36
Options for dealing with concerns	13.16	25.84
Calm down	12.37	15.36
Warm, caring, compassionate, empathic, comfortable to talk to, soothing, supportive, reassuring	15.79	13.11
Available, patient	12.63	11.23
Prevented suicide	13.94	1.12

Selected Community Outcomes

Four centers provided an average of 15 local community agencies each, yielding a total of 60 agencies. A representative from each agency was surveyed by an independent evaluator as to their familiarity and interactions (i.e. provide/receive referrals, training, or consultation) with the crisis centers, and the quality of services provided by the crisis center to the local community. The following table provides a summary of their feedback as to the quality of the crisis, prevention, referrals, information, and training/consultation services provided by centers. Community agencies were most familiar with crisis, referrals, and information services provided by centers; and, least familiar with training/consultation services. When asked to rate the importance of the crisis center to the community, agency representatives responded as follows: essential (74.6%), nice to have (20.3%), problematic (5%; 3 responses: not well trained, mobile crisis response too long, not doing what supposed to do).

Community Feedback on Service Quality[1]

	Crisis Intervention	Prevention Programs	Referrals	Information	Training/Consultation
Excellent	32.2	11.7	15.0	13.3	13.3
Good	30.5	20.0	38.3	41.7	14.2
Fair	8.5	8.3	8.3	6.7	5.0
Poor	5.1	1.7	1.7	1.7	.83
Don't Know	23.7	58.3	36.7	36.7	66.7

1. Percent of respondents

CONCLUSIONS

The study had some limitations, the most important of which was the fact that it was not possible to employ a control group design. Thus the effects cannot necessarily be contributed to the crisis interventions. Also some selection biases exist in regard to the centers that agreed to participate, the staff who agreed to conduct assessments, and the callers who consented to receive follow up calls. In regard to the latter, suicide callers who were assessed at follow up, as compared to those who were not followed were at less suicide risk, while crisis callers who were assessed at follow up, as compared to those who were not, were not significantly different with regard to baseline distress measures.

With these caveats in mind, the following conclusions may be in drawn from this evaluation study:

- Among crisis callers, distress decreases during and after calls.
- Crisis hotlines are reaching seriously suicidal callers.
- Suicidality decreases during and after calls.
- Caller feedback supports the logic of crisis centers.
- Suicide risk assessments need to be done routinely on all crisis calls…otherwise, "crisis" callers' suicidality can be missed.